Supreme Court, U.S.
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No. _____

In the Supreme Court of the United States

STATE OF MINNESOTA,

Petitioner,

v.

JOAN MARTIN, GUARDIAN AD LITEM FOR TROY HOFF,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE MINNESOTA SUPREME COURT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Social Security Act requires that states participating in the Medicaid program diligently pursue reimbursement of state and federal medical assistance payments when third parties are responsible for the injuries causing those expenditures. *See* 42 U.S.C. § 1396a(a)(25). The Act elaborates upon that requirement by specifically mandating that medical assistance recipients assign to the state any rights they may have to payment from a third party for medical care. 42 U.S.C. § 1396k. It also gives reimbursement of medical assistance priority when collections under such assignments are made. *Id.* Accordingly, Minnesota and all other states, with federal agency approval, have enacted some combination of assignment, lien and subrogation statutes to recoup medical assistance payments from responsible third parties.

The Minnesota Supreme Court has ruled, however, that a provision of the Social Security Act that prohibits states from placing a lien on a medical assistance recipient's property during his or her lifetime, 42 U.S.C. § 1396p(a)(1), preempts lien statutes such as Minnesota's. The court also held that federal law permits state assignment and subrogation statutes to reach only those third party payments that are designated for medical care. This case thus presents the following questions:

1. Does 42 U.S.C. § 1396p(a)(1) prohibit states from placing a lien for the cost of government-paid medical care on all causes of action or recovery rights that an injured medical assistance recipient may have?

2. Does the assignment provision of 42 U.S.C. § 1396k(a) prohibit states from recouping government-paid medical costs from *all* recoveries that a medical assistance recipient is entitled to receive from third parties before the recipient can recover any sums for him or herself?

TABLE OF CONTENTS

QUESTIONS PRESENTED i

TABLE OF AUTHORITIES v

PETITION FOR WRIT OF CERTIORARI 1

OPINIONS BELOW 1

JURISDICTION 1

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED 1

STATEMENT 3

A. Federal Statutory and Regulatory Background 4

1. The Medicaid Program in General 4

2. Third Party Recovery and Assignment Provisions 5

3. The "Anti-Lien Provision" 7

B. Minnesota Laws Requiring Third Party Recovery 7

1. Minnesota's Assignment Provision 7

2. Minnesota's Lien and Subrogation Provisions 8

C. Procedural History 8

1. The Accident and Medical Assistance Payments 8

2. The District Court Litigation 9

3. Minnesota Appellate Decisions 10

a. The *Martin* Majority Decision 10

b. The *Martin* Dissenting Opinion 11

4. Minnesota's Application for Rehearing and a Stay .. 13

REASONS FOR GRANTING THE PETITION 13

A. Certiorari Is Appropriately Granted Because A Substantial Conflict Exists Between *Martin* And Decisions Of Other Courts On The Same Issue 15

1. *Martin* Directly Conflicts with the Decisions of the Highest Courts of Three Sister States 15

2. *Martin* Conflicts with Decisions from Other Courts Concerning a State's Ability to Recoup Its Medical Assistance Expenses From All Portions of a Third Party Recovery 18

B. Certiorari Is Appropriately Granted Because *Martin* Directly Conflicts With Adjudications And Interpretations Rendered By The United States Department Of Health And Human Services 20

1. The DAB Decisions Are Entitled to Deference 21

2. HHS' Interpretations Allow States to Place Liens on Third Party Claims 23

C. Certiorari Is Appropriately Granted Because This Case Presents A Question Of Significant National Importance 24

D. *Martin* Is Wrong As A Matter Of Law Because It Misapplied Federal Preemption Doctrine And Minimized A Key Purpose Of The Act 27

CONCLUSION 30

TABLE OF AUTHORITIES

CASES

Atkins v. Rivera, 477 U.S. 154 (1986) 4

Bldg. & Constr. Trades Council v. Associated Builders & Contractors of Mass./R.I., 507 U.S. 218 (1993) 27

Calvanese v. Calvanese, 688 N.Y.S.2d 479, 710 N.E.2d 1079 (1999) 18, 19

Chevron, U.S.A., Inc. v. Natural Res. Def. Council, 467 U.S. 837 (1984) 20

Cricchio v. Pennisi, 660 N.Y.S.2d 679, 683 N.E.2d 301 (1997) 11, 15, 17, 18

Erlenbaugh v. United States, 409 U.S. 239 (1972) 28

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987) 28

Grey Bear v. North Dakota Dep't of Human Servs., No. 99-C-01007 (Burleigh Co. April 5, 2001) *appeal docketed*, No. 20010241 (N.D. Oct. 1, 2001) 26

Houghton v. Dep't of Health., No. 9508071CV (Salt Lake Co. Nov. 3, 2000) *appeal docketed*, No. 20001103-SC (Utah Dec. 14, 2000) 26

Martin v. City of Rochester, 642 N.W.2d 1 (Minn. 2002) .... passim

Merrill Lynch, Pierce, Fener & Smith, Inc. v. Ware, 414 U.S. 117 (1973) 27, 28

Norwest Bank v. Doth, 159 F.3d 328 (8th Cir. 1998) 4, 15, 18

Radzanower v. Touche Ross & Co., 426 U.S. 148 (1976) 28, 29

S.S. v. State, 972 P.2d 439 (Utah 1998) 16

Schweiker v. Gray Panthers, 453 U.S. 34 (1981) 4, 5

Skidmore v. Swift & Co., 323 U.S. 134 (1944) 20

Sullivan v. County of Suffolk,
174 F.3d 282 (2d Cir. 1999) 4, 18, 19, 20

Thomas Jefferson Univ. v. Shalala, 512 U.S. 504 (1994) 21

United States v. Mead Corp., 533 U.S. 218 (2001) 20

Wallace v. Estate of Jackson, 972 P.2d 446 (Utah 1998),
cert. denied, 528 U.S. 810 (1999) 11, 16, 17

Wilson v. State, 142 Wash.2d 40, 10 P.3d 1061 (2000),
cert. denied, 532 U.S. 1020 (2001) 11, 15, 16

Wisconsin Dep't of Health and Family Servs. v. Blumer,
534 U.S. 473, 122 S. Ct. 962 (2002) 20, 21, 23, 28, 29

STATUTES

28 U.S.C. § 1257(a) (2000) 1

42 U.S.C. § 1396a(a)(25) (2000) i

42 U.S.C. § 1396a(a)(25)(A) (2000) ..... *passim*

42 U.S.C. § 1396a(a)(25)(B) (2000) 1, 2, 5

42 U.S.C. § 1396a(a)(25)(H) (2000) ..... *passim*

42 U.S.C. § 1396a(a)(45) (2000) 28

42 U.S.C. § 1396k (2000) ..... i, 17, 19

42 U.S.C. § 1396k(a) (2000) ..... i, 2, 22

42 U.S.C. § 1396k(a)(1)(A) (2000) 5, 6

42 U.S.C. § 1396k(a)(1)(C) (2000) 6

42 U.S.C. § 1396k(b) (2000) ..... *passim*

42 U.S.C. § 1396p (2000) 15, 23

42 U.S.C. § 1396p(a)(1) (2000) ..... *passim*

42 U.S.C. §§ 1396-1396v (1965) 4

42 U.S.C. §§ 1396-1396v (2000) 7

42 C.F.R. § 430.0 (2001) 28

42 C.F.R. §§ 430.0 - 430.48 (2001) 4

42 C.F.R. § 430.35 (2001) 4

42 C.F.R. §433.140(a)(1) (2001) 4

Idaho Code § 56-209b(5) (Michie 2001) 25

Minn. Stat. § 256B.042, subd. 1 (2000) 8, 9

Minn. Stat. § 256B.056, subd. 6 (2000) 8

Minn. Stat. § 256B.37, subd. 1 (2000) 8

Minn. Stat. ch. 256B (2000) 7

Utah Code Ann. § 26-29-5(b) (2001) 25

W. Va. Code Ann. § 9-5-11(a) (2001) 25

Wash. Rev. Code Ann. § 74.09.185 (2002) 25

OTHER AUTHORITIES

California Dep't of Health Servs., DAB No. 1504, 1995 WL 66334 (Dep't of Health and Human Servs. Jan. 5, 1995) 21, 22

H.R. REP. 95-393(II) (1977), *reprinted in* 1977 U.S.C.C.A.N. 3039 29

S. REP. No. 99-146 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42 ..... 4, 20, 29

Washington State Dep't of Soc. & Health Servs., DAB No. 1561, 1996 WL 157123 (Dep't of Health and Human Servs. Feb. 7, 1996) 22, 23

PETITION FOR WRIT OF CERTIORARI

The Attorney General of Minnesota, on behalf of the State of Minnesota, respectfully petitions for a writ of certiorari to review the judgment of the Supreme Court of Minnesota in this case.

OPINIONS BELOW

The opinion of the Minnesota Supreme Court is reported at 642 N.W.2d 1 (Minn. 2002), 2002 WL 433356 (Minn. Mar. 21, 2002). App. at 1.[1] The opinion of the Minnesota Court of Appeals is reported at 615 N.W.2d 867 (Minn. Ct. App. 2000). App. at 68. The opinion of the district court, which was incorporated in the order granting Martin's motion for dismissal, is unpublished. App. at 78.

JURISDICTION

The judgment of the Minnesota Supreme Court was entered on March 21, 2002. App. at 1. Petitioner filed a timely motion for rehearing, which was denied by an order filed April 23, 2002. App. at 84. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a) (2000).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

42 U.S.C. § 1396a(a)(25)(A) and (B) (2000) provide, in relevant part:

> A State plan for medical assistance must - . . .
> (25) provide -
>
> (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties . . . to

[1] "App." refers to the separately bound Appendix To The Petition For A Writ Of Certiorari.

pay for care and services available under the plan . . .

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability[.]

App. at 85-86.

42 U.S.C. § 1396k(a) and (b) (2000) provide, in relevant part:

(a) [A] State plan for medical assistance shall –

1) provide that, as a condition of eligibility for medical assistance . . . the individual is required–

A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to . . . payment for medical care from any third party; . . .

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to

> the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

App. at 89-91.

42 U.S.C. § 1396p(a)(1) (2000) provides in relevant part: "No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid . . . ." App. at 92.

Relevant social security regulations pertaining to third party liability matters, App. at 106-47; legislative history, App. at 170-75, 288-93; and Minnesota state statutes, App. at 148-69; are set forth in the appendix.

STATEMENT

Under federal law, states participating in the Medicaid program are required to pursue reimbursement of state and federal medical assistance payments when third parties are responsible for the injuries underlying these expenditures. This mandate underscores Congress' intent that Medicaid be a payer of last resort and that Medicaid dollars be used only when no other resources are available.

Consistent with this intent and the cooperative federalism embodied by this joint federal-state program, Congress set minimum requirements that states must follow in pursuing third party recoveries. Congress largely left the states free to choose the types of recovery methods that they would employ. Accordingly, states have used several methods to recover medical assistance expenditures from responsible third parties. Most states, including Minnesota, enacted a combination of assignment, subrogation and lien statutes that were specifically endorsed by the federal agency charged with administering the Medicaid program. These methods have proven to be effective in recovering millions of state and federal Medicaid dollars.

This case raises the question of whether federal Medicaid law preempts these third party recovery methods that Minnesota and most other states have used to recoup medical assistance expenditures from responsible third parties. This question is extremely important not only to Minnesota, but to other states using the same or similar recovery methods employed by Minnesota before this decision by the Minnesota Supreme Court.

A. Federal Statutory And Regulatory Background.

1. The Medicaid Program in General.

Enacted in 1965 as Title XIX of the Social Security Act, Medicaid is a publicly funded program that pays for needed medical care for people whose income and resources are insufficient to meet the cost of the required care. *See* 42 U.S.C. §§ 1396-1396v (1965); *Atkins v. Rivera*, 477 U.S. 154, 156 (1986) (citation omitted). States choosing to participate in the Medicaid program must comply with the Act's requirements and with regulations promulgated by the United States Secretary of Health and Human Services ("HHS"). *See, e.g., Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981). A state failing to comply with federal requirements may be penalized by a reduction or a complete withholding of the state's federal funding. *See* 42 C.F.R. §§ 430.35, 433.140(a)(1) (2001). HHS' Centers for Medicare and Medicaid Services ("CMS"), previously known as the Health Care Financing Administration ("HCFA"), administers the Medicaid program federally. *See generally* 42 C.F.R. §§ 430.0 - 430.48 (2001).

In enacting the Medicaid program, Congress intended that Medicaid be the payment source of last resort and that all other available resources be used before Medicaid funds are made available to eligible recipients. *See, e.g., Sullivan v. County of Suffolk*, 174 F.3d 282, 285 (2d Cir. 1999); *Norwest Bank v. Doth*, 159 F.3d 328, 333 (8th Cir. 1998); *see also* S. REP. No. 99-146 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312.

Sound policy and fiscal considerations underlie Congress' intent, including ensuring that sufficient funds remain for future Medicaid recipients, and lessening the burdens on state and federal taxpayers. *Cf. Schweiker*, 453 U.S. at 48 ("There are limited resources to spend on welfare.").

2. Third Party Recovery and Assignment Provisions.

The Social Security Act does not authorize the federal government to recover Medicaid expenditures directly from third parties. Instead, the Act protects the federal fisc by explicitly requiring states to pursue these recoveries and then to reimburse the federal government for its share. For example, federal law requires that states take "all reasonable measures to ascertain the legal liability of third parties" and to seek reimbursement "to the extent of such liability." 42 U.S.C. § 1396a(a)(25)(A), (B). Specifically, the Act requires that:

> [I]n any case where a third party has a legal liability to make payment for [medical] assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, *the State is considered to have acquired the rights of such individual to payment by any other party* for such health care items or services[.]

42 U.S.C. § 1396a(a)(25)(H) (2000) (emphasis added).

In addition, each state must require Medicaid recipients, as a condition of Medicaid eligibility, to assign to the state their rights to payment for medical care from any liable third party. *See* 42 U.S.C. § 1396k(a)(1)(A). This provision provides in pertinent part:

> [A] State plan for medical assistance shall –

> 1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required –
>
> A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to . . . payment for medical care from any third party[.]

Id. This provision also places a duty on the recipient to "cooperate with the State" in identifying and helping the State to pursue potentially liable third parties. *Id.* at subd. (a)(1)(C).

The federal assignment provision further mandates that states must be paid first from a third party recovery. Section 1396k(b) requires:

> Such part of any amount collected by the State under an assignment . . . shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396k(b). This provision explicitly requires that any balance the state recovers beyond that which it has already paid shall be reimbursed to the Medicaid recipient. *Id.*

3. The "Anti-Lien Provision."

A separate provision of the Act, the "anti-lien provision," protects a Medicaid recipient's property from liens related to these medical expenditures during the recipient's lifetime. 42 U.S.C. § 1396p(a)(1) (2000). This provision provides in relevant part that "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid." *Id.*

B. Minnesota Laws Requiring Third Party Recovery.

The State of Minnesota ("Minnesota" or "the State") participates in the federal Medicaid program through its "Medical Assistance" ("MA") program, jointly financed by the federal government and the State, and administered by the State.[2] *See generally* Minn. Stat. ch. 256B (2000) and 42 U.S.C. §§ 1396-1396v (2000). To comply with the federal directive that states pass laws to ensure recovery of Medicaid expenditures from responsible third parties, Minnesota enacted three recovery methods. Using these statutes, Minnesota has recouped about seven million dollars each year in Medical Assistance payments during the years 1996 through 1999; fifty percent of these recoveries are HHS' share of expenditures.

1. Minnesota's Assignment Provision.

First, as required by the federal assignment provision, Minnesota mandated that potential Medical Assistance recipients, as a condition of eligibility, assign to the State rights to certain payments from liable third parties. Minnesota's assignment statute provides in pertinent part:

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[2] On average, the federal government pays approximately fifty percent (50%) of Minnesota's MA.

> To be eligible for medical assistance a person must have applied or must agree to apply *all proceeds* received or receivable by the person or the person's spouse from any third person liable for the costs of medical care for the person, the spouse, and children. The state agency shall require from any applicant or recipient of medical assistance the assignment of any rights to medical support and third party payments.

Minn. Stat. § 256B.056, subd. 6 (2000) (emphasis added).

2. Minnesota's Lien and Subrogation Provisions.

Second, Minnesota's MA lien provision allows the State to place a lien for the cost of the care "upon any and all causes of action or recovery rights" that accrue to recipients or their legal representatives as a result of injuries requiring medical care. *See* Minn. Stat. § 256B.042, subd. 1 (2000). Third, Minnesota's subrogation statute provides that the State is subrogated, "to the extent of the cost of medical care furnished, to any rights the person may have under . . . the cause of action." Minn. Stat. § 256B.37, subd. 1 (2000). The statute specifically includes "all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation." *Id.*

C. Procedural History.

1. The Accident and Medical Assistance Payments.

On July 10, 1991, Troy Hoff was injured when the car in which he was riding was involved in a single-car accident in Rochester, Minnesota. App. at 10. Hoff suffered permanent and totally disabling injuries and the driver, Donald Tlougan, was killed. App. at 10.

After the accident, Hoff's mother, Joan Martin, filed an application for MA on behalf of Hoff. App. at 10. On

November 25, 1991, the Minnesota Department of Human Services ("DHS") began making MA payments on behalf of Hoff. App. at 10. As part of the MA application that Martin signed on behalf of Hoff, Martin assigned to Minnesota "any rights to payment for medical care from any third party for myself or my dependents." App. at 79.

On June 21, 1993, relying upon Minnesota's lien statute permitting liens "upon any and all causes of action or recovery rights," the State filed a $267,754.50 public assistance lien for the costs of the medical care provided to Hoff up to that time. App. at 11, 80. The lien also provided for "future medical assistance benefits to be paid as a consequence of the accident." App. at 11. To date, Minnesota has paid over $600,000 for Hoff's medical expenses, and he continues to receive medical care paid for by the state and federal government. App. at 54.

2. The District Court Litigation.

On September 2, 1993, Martin, as guardian ad litem for Hoff, commenced a tort action against the Estate of Tlougan, City of Rochester, Rochester Township and County of Olmsted. App. at 11.[3] In addition to seeking damages for pain and suffering, disability, past loss of earnings, loss of earning capacity, and other general and specific damages, Martin also sought damages for Hoff's past and future medical care and treatment. App. at 11. Martin joined Minnesota as a plaintiff on impleader. App. at 11. In its Answer and Cross-claim, Minnesota asserted a right to reimbursement, relying upon the lien statute, section 256B.042, subd. 1. App. at 12. Minnesota also asserted a right to recover MA benefits based upon the assignment provision included in the MA application. App. at 12 n.3. Relying upon these rights, Minnesota did not actively participate in the underlying litigation. App. at 12.

[3] Martin subsequently dismissed County of Olmsted from her action. App. at 11 n.2.

After reaching settlements in 1999 with the three Defendants for a total of $220,000, Martin moved to dismiss the State's claims. App. at 12, 14. Martin contended that Minnesota's lien and subrogation statutes were preempted by the federal anti-lien provision of 42 U.S.C. § 1396p(a)(1). App. at 14. On February 29, 2000, the Olmsted County District Court granted Martin's motion to dismiss, and invalidated Minnesota's lien and subrogation statutes on federal preemption grounds. App. at 80-82.

3. Minnesota Appellate Decisions.

Upon appeal, the Minnesota Court of Appeals unanimously reversed the district court, holding that federal law does not preempt Minnesota's lien statute. App. at 76. The court of appeals cited analyses adopted in recent decisions by the Utah Supreme Court and two federal courts of appeal that considered the same issue. App. at 74-75.

Martin successfully petitioned for review by the Minnesota Supreme Court.[4] On March 21, 2002, after considering the matter for over a year, the Minnesota Supreme Court entered its judgment in *Martin v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002). App. at 1.

a. The *Martin* Majority Decision.

In a four-three opinion, the majority reversed the Minnesota Court of Appeals and held that Minnesota's lien statute was preempted by the federal anti-lien provision of 42 U.S.C. § 1396p(a)(1). App. at 30-31. It found that compliance with Minnesota's MA lien statute and the federal anti-lien provision was impossible. App. at 31.

The majority further held that Minnesota's assignment and subrogation statutes conflicted with its assessment of the purpose of the anti-lien provision – "to protect the recipient's

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[4] The Minnesota Trial Lawyers' Association, ARC Minnesota, Inc., and NYSARC, Inc., filed two amicus briefs on behalf of Martin.

limited assets, including nonassigned rights to recover." App. at 34. Thus, the court narrowly construed the federal assignment statute and, accordingly, Minnesota's assignment statute so that the State has assignment rights to "all proceeds *for medical care*, but does not have rights in any other part of a recovery." App. at 36. As a result, Minnesota can no longer recover its medical expenditures from those portions of a recovery that have been designated for reimbursement of non-medical care damages. App. at 37. Because Minnesota's subrogation statute allowed the State to recoup Medical Assistance from *all* third party causes of action or recoveries, the majority also concluded that the subrogation statute was preempted. App. at 38-40.

In reaching this result, the majority accorded no deference to federal agency adjudications and interpretations concerning the states' ability to use such measures to recoup medical expenditures from responsible third parties. App. at 41-42. Nor did it agree with the results reached in cases from other jurisdictions that directly supported Minnesota's position. App. at 44-47. *See Wilson v. State*, 142 Wash.2d 40, 10 P.3d 1061 (2000), *cert. denied*, 532 U.S. 1020 (2001); *Wallace v. Estate of Jackson*, 972 P.2d 446 (Utah 1998), *cert. denied*, 528 U.S. 810 (1999); *Cricchio v. Pennisi*, 660 N.Y.S.2d 679, 683 N.E.2d 301 (1997).

b. The *Martin* Dissenting Opinion.

Three Justices of the Minnesota Supreme Court joined a dissenting opinion and stated at the outset:

> The majority's holding is contrary to the purposes of the federal Medicaid law. The majority purports to construe the federal statute as a whole and interpret the federal anti-lien provision in light of the surrounding sections, but ultimately fails to adequately address the federal requirement that states recoup their expenditures out of proceeds from liable third parties . . . . Focusing on the

> anti-lien provision, the court allows parties to subvert the principle that Medicaid should be the payor of last resort . . . .

App. at 54.

The dissent rejected the majority's narrow reading of the federal third party recovery language of 42 U.S.C. § 1396a(a)(25)(H). App. at 56-57. The dissent found that "Congress' intent is to limit the recovery only 'to the extent that payment has been made under the State plan,' not to amounts out of a third party settlement that the recipient agrees to label payment for medical expenses." App. at 57 (quoting 42 U.S.C. § 1396a(a)(25)(H)). The dissent argued that the broad assignment under state law of "all proceeds received or receivable" from any liable third party thus conforms with and advances the purposes of federal law. App. at 57.

Further, given this broad assignment, the dissent found that the federal anti-lien provision posed no bar to state third party recovery attempts. App. at 55. Once Martin assigned Minnesota broad rights to third party payment, as she did when she applied for MA on behalf of her son, "the anti-lien provision was no longer operative because the recipient's causes of action (to the extent of the state's expenditures) were no longer [Hoff's] property." App. at 55.

In addition, the dissent pointed out that, "despite contrary results reached in every other court that has considered the question presented in this case, the majority fails to acknowledge even an ambiguity that would allow it to defer to the federal agency charged with day-to-day administration of this complex statute." App. at 54. The dissent believed that two decisions of HHS' Departmental Appeals Board were entitled to deference; these decisions found that the federal assignment provision was *not* limited only to payment for medical care. App. at 62, 65.

4. Minnesota's Application for Rehearing and a Stay.

On April 1, 2002, the State filed a timely petition for rehearing, requesting that the Minnesota Supreme Court stay its decision and give it prospective application only. The application was denied on April 23, 2002. App. at 84. Minnesota sought to stay the Minnesota Supreme Court's judgment before the Honorable Clarence Thomas as the Circuit Justice for the Eighth Circuit. On May 13, 2002, Justice Thomas issued a temporary stay pending receipt of a response and further order by Justice Thomas or the Court. App. at 193. After Martin responded, Justice Thomas vacated the earlier stay. App. at 194. On May 23, 2002, Minnesota filed an Application to Reopen Application to Stay Judgment Based Upon a Misrepresentation of Material Fact. After reinstating the stay pending further order, Justice Thomas issued a final order on May 30, 2002, vacating the stay and denying Minnesota's stay application. App. at 195-96.

REASONS FOR GRANTING THE PETITION

This case involves a matter of considerable national importance concerning cooperative federalism in the context of the Medicaid program, deference to the federal agency charged with administering the program, and recovery of millions of dollars in state and federal medical assistance expenditures. In striking down Minnesota's third party recovery statutes, the Minnesota Supreme Court misconstrued the Medicaid provisions of the Social Security Act, improperly substituted its own views in place of the long-standing, reasoned and consistent interpretations of the federal agency entrusted with administering the Medicaid program, and undercut the discretion that Congress had afforded the states. The Court should grant this petition for four reasons.

First, the Minnesota Supreme Court's decision in *Martin* directly conflicts with decisions of the highest courts of

Washington, Utah and New York on the same issue: whether states may recover medical assistance payments from responsible third parties by placing a lien on any anticipated recovery. *Martin* further conflicts with other federal and state court decisions by holding that a state may only recoup its medical assistance expenditures from the portion of a third party recovery specifically allocated for medical expenses.

Second, *Martin* conflicts with adjudications and interpretations issued by the federal agency administering the complex Medicaid laws in question. HHS has consistently taken the position that states may place liens on third party recoveries without running afoul of the federal anti-lien provision. Moreover, two Departmental Appeals Board decisions hold that states must recoup medical assistance payments in full before a recipient may recover from a third party for any other claims.

Third, this case raises important questions of nation-wide significance. How state agencies recover medical assistance dollars from liable third parties is a vital issue to each state, involving thousands of third party claims, millions of dollars, and the breadth of states' discretion in administering their programs.

Finally, *Martin* is wrong as a matter of law. *Martin* misinterprets the Medicaid provisions of the Social Security Act and minimizes a key purpose of the Act - to ensure that Medicaid is a payer of last resort. In so doing, the decision misapplies federal preemption doctrine in the context of this joint federal-state program.

A. Certiorari Is Appropriately Granted Because A Substantial Conflict Exists Between *Martin* And Decisions Of Other Courts On The Same Issue.

1. Martin Directly Conflicts with the Decisions of the Highest Courts of Three Sister States.

Martin squarely conflicts with *Wilson, Wallace* and *Cricchio*. Like *Martin,* these decisions considered a challenge to their states' medical assistance lien statutes on federal preemption grounds. Like Martin, the challengers in these cases argued that the anti-lien provision of 42 U.S.C. § 1396p prohibited states from placing liens on medical assistance recipient's recovery rights. In finding that Minnesota's lien statute is preempted by federal law, the *Martin* majority simply dismissed each of these state supreme court decisions that harmonized the federal anti-lien provision with a state's duty to recover from responsible third parties. *See Wilson,* 142 Wash.2d at 45–46, 10 P.3d at 1065 – 66; *Cricchio,* 660 N.Y.S.2d at 680, 683 N.E.2d at 302.[5] Moreover, *Martin* created substantial tension with the Eighth Circuit's decision in *Norwest Bank,* which affirmed the State's right to recover its medical expenditures before a MA recipient can place a recovery into a special needs trust. 159 F.3d at 333.

a. *Wilson.* In *Wilson,* a guardian ad litem brought an action on behalf of a proposed class of persons who filed third party liability injury claims and had received medical assistance from the state for their injury-related medical expenses. 142 Wash.2d at 42, 10 P.3d at 1063. As in *Martin,*

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[5] The majority in *Martin* attempted to distinguish these cases by focusing on these courts' determinations that the liens were not placed on the "property" of the MA recipients, which the majority characterized as an avoidance of the preemption issue altogether. App. at 45-46. This characterization misconstrues these decisions, however, because it was through analyzing the federal prohibition against placing a lien on "property" that these courts reached the implicit conclusion that this federal provision does not apply to the states' third party recovery mechanisms.

the Washington Supreme Court was specifically asked to decide whether the state law, "which attempts to lien a Medicaid recipient's third party recovery beyond that portion specifically allocated to medical expenses, conflicts with the federal [anti-lien] law and is thus preempted." *Id.* at 42, 10 P.3d at 1063.

The *Wilson* court relied upon the state's assignment rights in holding that this federal provision did not bar Washington from pursuing settlement proceeds to satisfy its lien. It noted that federal law permitted a statutory assignment of rights to third party payments, and that the Medicaid recipient "assigned the right to payment to the extent paid out by the state." *Id.* at 44–47, 10 P.3d at 1064–66. The *Wilson* court held that, because Washington's lien was placed on the recovery "before it becomes the property of the Medicaid recipient . . . the department does not have a lien on 'property' of the recipient." *Id.* at 47, 10 P.3d at 1066. Given the timing of Washington's lien, the court thus found the federal anti-lien provision to be "irrelevant." *Id.* n.2. Accordingly, the state lien statute and federal anti-lien provision were found not to be in conflict.[6]

b. *Wallace.* Likewise, in *Wallace,* the Utah Supreme Court found that the federal anti-lien provision did not preempt Utah's medical assistance lien statute. *See Wallace,* 972 P.2d at 448; *see also S.S. v. State,* 972 P.2d 439, 442 (Utah 1998) (companion case). As in *Martin* and *Wilson,* the plaintiff in *Wallace* alleged that the federal anti-lien provision prohibited the state from asserting a lien against or seeking

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[6] *Wilson* also conflicts with the *Martin* majority's holding that a state can only recoup its medical assistance payments from the portion of a recovery specifically designated for medical expenses. In contrast to *Martin,* the Washington Supreme Court held that "the state is not limited to recovery from only that portion of the settlement specifically allocated to medical expenses. The federal statute states recovery is to the extent of payment made by the state for health care items or services." *Wilson,* 142 Wash.2d at 48, 10 P.3d at 1066.

recovery from the Medicaid recipient as opposed to the liable third party. *Wallace,* 972 P.2d at 447 - 48. The Utah Supreme Court rejected this claim, holding that payments made by a third party do not legally become the property of the recipient until after settlement "'because third party settlement proceeds have been specified by the recipient as belonging to the State Medicaid Agency as a precondition of the recipient's eligibility.'" *Id.* at 448 (quoting state's brief).

The Utah Court further noted that the anti-lien provision has "coexisted for many years with 42 U.S.C. § 1396a(a)(25)(A), a sister section of the [Social Security] Act, which mandates states to seek reimbursement from third parties who are legally liable for the medical payments." *Id.* By finding that the assigned rights are not part of the recipient's property, the *Wallace* Court harmonized the sections of the federal statute to avoid any conflict between them. *See id.*

c. *Cricchio.* In *Cricchio,* the New York Court of Appeals considered whether a Medicaid lien placed by New York "on the proceeds of a personal injury settlement must be satisfied before those funds may be transferred to a 'supplemental needs trust.'" 660 N.Y.S.2d at 680, 683 N.E.2d at 302. The plaintiffs argued that the lien could not be satisfied until the Medicaid recipient's death, based upon the federal anti-lien provision. *Id.* at 682, 683 N.E.2d at 304.

In rejecting that contention, the *Cricchio* Court found that because the injured Medicaid recipient had assigned his recovery rights to New York, as required under 42 U.S.C. § 1396k, "the settlement proceeds are resources of the third-party tortfeasor that are owed to [the state]." *Id.* at 683, 683 N.E.2d at 305. It further explained:

> Accordingly, the lien on the settlement proceeds attaches to the property of the third party, and thus does not violate the statutory prohibition against imposing a lien against a beneficiary's property until after his or her death. The flaw in plaintiffs' theory that the lien cannot be satisfied until the

> recipient's death is that it fails to appreciate this critical distinction between the assets of a responsible third party and assets belonging to the Medicaid recipient.

Id. (citations omitted). In so ruling, the court noted that the "legal liability of any responsible third party to reimburse Medicaid for care . . . is a cornerstone of the Medicaid program." *Id.*

d. *Norwest Bank.* In *Norwest Bank,* the Eighth Circuit Court of Appeals held that Minnesota may satisfy its lien from settlement proceeds before funds are placed in a special needs trust under the federal assignment statute. 159 F.3d at 333. The court declined to rule on the effect of the federal anti-lien provision, however, because that particular issue had not been timely raised. *Id.* at 333 - 34. Nonetheless, in holding that a Medicaid recipient may not "evade an existing state lien by placing the proceeds in a [special needs trust]," the Eighth Circuit observed that the opposite result "would 'eviscerate Congress's clearly expressed intention that these funds be repaid' and negate the 'Social Security Act's comprehensive scheme permitting states to place these liens.'" *Id.* at 333 (citations omitted).

2. *Martin* Conflicts with Decisions from Other Courts Concerning a State's Ability to Recoup Its Medical Assistance Expenses From All Portions of a Third Party Recovery.

Martin also conflicts with decisions from other courts relating to a state's ability to recover its full medical assistance claim from an entire settlement, regardless of the settlement's apportionment. *See Calvanese v. Calvanese,* 688 N.Y.S.2d 479, 482, 710 N.E.2d 1079, 1082 (1999); *Sullivan,* 174 F.3d at 286. The *Martin* Court's ruling that Minnesota's recovery is limited to that portion of a settlement agreement that is specifically designated as "medical expenses" is contrary to these decisions.

a. *Calvanese.* In *Calvanese,* New York's highest court was asked whether the *entire* amount of a personal injury settlement is available to satisfy a Medicaid lien, or only that portion specifically allocated to past medical expenses. 688 N.Y.S.2d at 480, 710 N.E.2d at 1080. After analyzing the federal assignment and third party recovery provisions found in 42 U.S.C. §§ 1396a(a)(25)(H) and 1396k(b), the court rejected the appellant's argument that only the settlement proceeds specifically allocated to past medical expenses should be made available to satisfy the state's Medicaid lien. 688 N.Y.S.2d at 482, 710 N.E.2d at 1082 ("Nowhere in the elaborate statutory scheme governing this area of law . . . is the agency's right of recovery restricted in this manner."). The court further reasoned that creating such a restriction on the state's ability to recover its Medicaid expenditures "would weaken the assignment and subrogation provisions as well as the priority assigned to Medicaid liens, results that would jeopardize the ultimate goal of Medicaid - that the program be the payor of last resort." *Id.* at 482 - 83, 710 N.E.2d at 1082. Finally, the court noted that restricting the state from recovering its medical expenditures from an entire settlement based upon its allocation "would create an anomalous situation in which . . . Medicaid recipients could shield such funds from recoupment by the Department after having received significant public assistance." *Id.* at 482, 710 N.E.2d at 1082.

b. *Sullivan.* In *Sullivan,* the Second Circuit Court of Appeals held that, based on the federal assignment statute, the state may first satisfy its lien before any settlement proceeds are placed in a supplemental needs trust for the recipient. 174 F.3d at 286; *see also* 42 U.S.C. § 1396k. The court interpreted the federal assignment language to mean that the Medicaid recipient had "assigned his right to recover from a third party to [the state agency], *up to the amount of medical assistance provided.*" 174 F.3d at 286 (emphasis added). The court further held that the significance of this assignment was that "[the state agency] was entitled to *any rights* that

[the medical assistance recipient] had to third party reimbursement." *Id.* (emphasis added).

B. Certiorari Is Appropriately Granted Because *Martin* Directly Conflicts With Adjudications And Interpretations Rendered By The United States Department Of Health And Human Services.

The *Martin* decision directly conflicts with decisions by HHS' Departmental Appeals Board ("DAB") as well as with numerous interpretations by HHS. Formal federal agency adjudications, such as those issued by DAB, are granted full deference where the language of a statute is ambiguous or silent on the particular issue, and the interpretation is a permissible construction of the statute.[7] *Chevron, U.S.A., Inc. v. Natural Res. Def. Council,* 467 U.S. 837, 843 (1984); *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001) (citations omitted). In addition, agency interpretations not contained in regulations or adjudications are due a "respect proportional to [their] 'power to persuade'" given the "'specialized experience and broader investigations and information' available to the agency." *Mead Corp.*, 533 U.S. at 234–35 (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 139-40 (1944)).

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[7] HHS' adjudications and interpretations satisfy the second prong of the *Chevron* test, which requires that the agency interpretation be a "permissible construction of the statute." 467 U.S. at 843. These adjudications and interpretations are permissible because they underscore the federal law requirement that states be given broad authority to pursue third party recoveries. *See* 42 U.S.C. 1396a(a)(25)(A); *see also Wisconsin Dep't of Health and Family Servs. v. Blumer*, 122 S. Ct. 962, 965 (2002) (allowing for a permissible range of choices to the States in implementing the Medicaid program where HHS has found that such latitude is consistent with the statute's aims). Moreover, HHS' adjudications and interpretations support Congress' intent that all other available resources be used before Medicaid funds are made available to eligible recipients. *See* S. REP. No. 99-146 (1985), reprinted in 1986 U.S.C.C.A.N. 42, 312.

This Court recently addressed the level of deference accorded to HHS' interpretations of Medicaid program provisions in *Wisconsin Dep't of Health and Family Servs. v. Blumer*, 534 U.S. 473, ____, 122 S. Ct. 962, 975 - 77 (2002). In *Blumer*, this Court held that Wisconsin's use of an "income first" method, which HHS had specifically authorized in a "Regional State Letter," was a permissible approach under federal law for determining an institutionalized spouse's Medicaid eligibility. 122 S. Ct. at 976.

Upholding Wisconsin's use of this method, the Court noted that respectful consideration of a federal agency's interpretation is especially appropriate for the federal Medicaid agency, based upon its "'significant expertise'" in "'a complex and highly technical regulatory program.'" *Id.* (quoting *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994)). Moreover, this Court recognized the long-standing principle that Congress delegated "extremely broad regulatory authority to the Secretary in the Medicaid area." *Id.* n.13. Accordingly, this Court observed that "the leeway for state choices urged by both Wisconsin and the United States is characteristic of Medicaid." *Id.* at 975.

1. The DAB Decisions Are Entitled to Deference.

The *Martin* majority failed to accord appropriate deference to two decisions by DAB concerning the breadth of the federal assignment provision. In California Dep't of Health Servs., DAB No. 1504, 1995 WL 66334 (Dep't of Health and Human Servs. Jan. 5, 1995), HCFA specifically opposed California's practice of permitting recipients to keep portions of third party recoveries that did not represent payment for medical care. App. at 202-03. DAB upheld HCFA's interpretation of federal law as requiring full Medicaid reimbursement before the recipient collects any third party settlement proceeds. App. at 202-03, 210. In doing so, DAB explained that HCFA's position was "directly supported" by the Social Security Act. App. at 202. In

particular, DAB stated:

> Recipients, as a condition of eligibility, must assign their rights to payment for medical care. States are then charged with the responsibility of seeking third party recovery pursuant to such assignments. States are further required to seek as much reimbursement as possible, i.e., to the extent of the third party's liability. Finally, when a recovery is made, the Act sets forth a distribution scheme which requires the Medicaid program to be reimbursed prior to distributing any funds to the recipient. *While* [42 U.S.C. § 1396k(a)] *refers to assignment only of "payment for medical care," the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first.*

App. at 202-03 (emphasis added). DAB also noted that this position was not unfair to Medicaid recipients:

> If Medicaid had not paid their medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlements . . . . [W]here Medicaid has incurred the "debt" for recipients, it is not unfair for HCFA to require complete reimbursement from these liability funds.

App. at 210.

Similarly, in Washington State Dep't of Soc. & Health Servs., DAB No. 1561, 1996 WL 157123 (Dep't of Health and Human Servs. Feb. 7, 1996), DAB upheld HCFA's determination that, under the mandatory federal assignment provision, Medicaid must be reimbursed in full before the recipient receives any settlement monies. It stated:

> [W]here there is a third party that is responsible for paying a recipient's medial expenses, the recipient may not recover money for him/herself until the

> federal government is reimbursed for its expenditures for the recipient's medical care . . . .
>
> HCFA may require a state to assert a collection priority over funds obtained by Medicaid recipients in [Third Party Liability] suits even though the distribution methodology set forth in [42 U.S.C. § 1396k(b)] refers only to payments collected pursuant to assignments for medical care.

App. at 220-21. DAB further stated unequivocally: "In cases where a third party has caused the need for medical care and is liable for its payment, the Act looks to the third party to reimburse the public." App. at 221.

2. HHS' Interpretations Allow States to Place Liens on Third Party Claims.

In addition, HHS, through HCFA/CMS, has clearly, consistently and repeatedly confirmed that the anti-lien provision does not prohibit states from placing liens on Medicaid recipients' third party claims. *See* App. at 235-45;[8] *see also Blumer*, 122 S. Ct. at 976 n.14 (acknowledging persuasive effect of HHS' Secretary's unwavering statements that a particular interpretation of a Medicaid provision was permissible). Moreover, HHS has explicitly *endorsed* and *recommended* states' use of lien statutes to recover Medicaid

[8] 1994 HHS Regional Identical Letter No. 94 – 134 to State Medicaid Directors (explaining that 42 U.S.C. § 1396p does not prohibit states' use of lien laws in third party recovery matters), App. at 235-36; 1996 HHS Medicaid Director Memorandum to All State Medicaid Directors (affirming states' authority to place a lien on a medical assistance recipient's third party recovery), App. at 239-40; and 1998 HHS Medicaid Director Letter to United States Congressman (explaining states' authority to assert a claim against a medical assistance recipient's third party recovery through use of a lien even if state was not a party to the litigation), App. at 244-45.

payments as a means of complying with federal law. *See* App. at 246-80.[9]

C. Certiorari Is Appropriately Granted Because This Case Presents A Question Of Significant National Importance.

The third reason for granting certiorari is that this case presents an important national question. The *Martin* decision calls into question the legitimacy of assignment, lien and subrogation statutes throughout the country and challenges the ability of all states to define the manner in which they will recover Medicaid expenditures as required under federal law. Federal law requires that every state that participates in the Medicaid program pass laws sufficient to ensure that "the State is considered to have acquired the rights of such individual to payment by any other party." 42 U.S.C. § 1396a(a)(25)(H). Those same laws, however, allow the states themselves to define the manner in which these payments are recovered. *See id.* The only federally imposed limitation is that the recovery be limited to the amount of "medical assistance payments made" *by the state.* 42 U.S.C. § 1396k(b). Recovery is not limited to the amount that the third party is willing to label as payments for medical assistance.

To comply with this federal requirement, *every state* has passed either a lien, assignment or subrogation law (or some combination of the three) similar to Minnesota's. At least fifteen states have elected, like Minnesota, to use lien statutes to recover their Medicaid expenditures, including Alaska, California, Colorado, Connecticut, Florida, Hawaii, Iowa,

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[9] HHS' Third Party Liability In the Medicaid Program Guide (describing specific states' lien and subrogation statutes, including Minnesota's, as "model legislation"), App. at 249-76; HHS' Third Party Liability: A State's Opportunity Guide (endorsing states' use of lien, subrogation and assignment laws), App. at 279-80.

Maine, Massachusetts, Montana, New York, Oregon, Pennsylvania, Utah and Washington.[10]

Some state statutes also specifically provide that the state's lien, assignment or subrogation interests may be recovered from any and all portions of an award or settlement against a liable third party, rather than *only* from those portions designated for medical expenses as required by the Minnesota Supreme Court. Washington's statute, for example, specifies that the state's recovery "shall not be reduced, prorated, or applied to only a portion of a judgment, award or settlement." Wash. Rev. Code Ann. § 74.09.185 (2002); *see also* W. Va. Code Ann. § 9-5-11(a) (2001) (providing that the state's subrogation right "includes *all* portions of the [recipient's] cause of action . . . notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to the subrogation") (emphasis added).[11]

Moreover, some state legislatures have explicitly given the state's medical assistance recovery priority over other claims the injured party may have. *See, e.g.*, Utah Code Ann. § 26-29-5(b) (2001) (granting the state's lien against third party proceeds "priority over all other claims to the proceeds" except for attorney's fees and costs); Idaho Code § 56-209b(5) (Michie 2001) (granting the state's subrogation right "priority to any amount received from a third party which . . . compensate[s] the recipient for the occurrence giving rise to the need for medical assistance").[12] Therefore, numerous states, and thousands of medical assistance recipients receiving millions of dollars worth of medical care

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[10] *See, e.g.*, App. at 281 for a compilation of these state lien statutes.

[11] *See e.g.*, App. at 282-85 for excerpts from twelve state statutes providing Medicaid reimbursement from entire third party settlements or awards.

[12] *See, e.g.*, App. at 286-87 for excerpts from eight state statutes granting priority to Medicaid claims.

each year throughout the nation, will be affected if their jurisdictions adopt the *Martin* Court's restrictive interpretation of the federal Medicaid program's third party recovery provisions.

Minnesota's ruling has already created a split among the states relating to their rights to elect certain recovery methods under federal law, and allowing this chasm to deepen will result in sharply inequitable recovery systems among the states. While all state supreme courts addressing this issue have decided the matter in direct contrast to *Martin,* several other state courts will be addressing this issue shortly.[13] As a direct result of *Martin,* many other states are likely to receive challenges to their third party recovery statutes, which were fashioned under the same federal agency interpretation that guided the enactment of Minnesota's third party recovery laws.

States whose highest courts adopt the *Martin* Court's reasoning will be required to intervene directly in ongoing litigation, or file independent actions against third party tortfeasors, to recover their medical expenditures. Because of *Martin,* Minnesota is currently in the process of intervening in hundreds of cases, experiencing a substantial increase in expenditures of staff time and financial resources. Requiring states to pursue third parties directly to recover publicly funded medical costs, instead of using lien or subrogation statutes to do so, would result in states-- like Minnesota-- spending much more money to recover the same amount of funds. Of course, increased collection expenses reduce the

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[13] *See, e.g., Houghton v. Dep't of Health,* No. 9508071CV (Salt Lake Co. Nov. 3, 2000), *appeal docketed,* No. 20001103-SC (Utah Dec. 14, 2000) (addressing whether statute granting Medicaid priority reimbursement violates the federal anti-lien statute); *Grey Bear v. North Dakota Dep't of Human Servs.,* No. 99-C-01007 (Burleigh Co. April 5, 2001), *appeal docketed,* No. 20010241 (N.D. Oct. 1, 2001) (addressing whether federal and state law require reimbursement to Medicaid from all third party proceeds whether or not the proceeds include compensation for pain and suffering).

ultimate return to the state and federal government of their medical assistance funds. Thus, this requirement will dramatically increase litigation and recovery costs for states, and further limit their recoveries only to those portions specifically designated for medical expenses.

In contrast, states whose highest courts follow the analysis of HHS will not be required to litigate their medical assistance third party recovery claims directly; nor will they be prevented from recovering their full claims from a medical assistance recipient's recovery despite a settlement disposition to the contrary. A ruling by this Court on these issues would clarify a state's authority under federal law to use existing third party recovery methods, including liens, to recover federal and state Medicaid dollars.

D. *Martin* Is Wrong As A Matter Of Law Because It Misapplied Federal Preemption Doctrine And Minimized A Key Purpose Of The Act.

Certiorari is properly granted in this case because *Martin* misapplied federal preemption doctrine and undercut a primary purpose of the Act, that Medicaid be the payer of last resort. By failing to acknowledge the broad discretion accorded to states to create and to administer their medical assistance programs, and the high standard that must be met before a state statute can be held unconstitutional on federal preemption grounds, *Martin* ignored well-established principles of preemption. The decision also ignored key canons of statutory construction.

"Consideration under the Supremacy Clause starts with the basic assumption that Congress did not intend to displace state law." *Bldg. & Constr. Trades Council v. Associated Builders & Contractors of Mass./R.I.*, 507 U.S. 218, 224 (1993) (citations and internal quotes omitted). Thus, this Court has stated that it is "reluctant to infer preemption." *Id.* (citations omitted); *see also Merrill Lynch, Pierce, Fener & Smith, Inc. v. Ware*, 414 U.S. 117, 127 (1973) (recognizing in a Security Exchange Act case that the "sensitive interrelationship between statutes adopted by the separate,

yet coordinate, federal and state sovereignties" should temper a court's analysis "by the conviction that the proper approach is to reconcile 'the operation of both statutory schemes with one another rather than holding one completely ousted'") (quotation omitted). Moreover, in any preemption analysis, "the purpose of Congress is the ultimate touchstone." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) (citations and internal quotations omitted).

In addition, a basic principle of statutory construction provides that related statutes must be read in pari materia, keeping in mind the purposes of the entire federal scheme. *See Erlenbaugh v. United States*, 409 U.S. 239, 243-44 (1972). In particular, one federal law should not be read to amend another unless they are "in irreconcilable conflict." *Radzanower v. Touche Ross & Co.*, 426 U.S. 148, 153-54 (1976).

In the Medicaid third party recovery arena, Congress has explicitly conferred broad authority upon the states to pass laws to recoup medical assistance payments from liable third parties.[14] Unlike laws like ERISA that explicitly preempt state law, the Medicaid statute specifically *requires states* to determine appropriate methods of recovery. *See Blumer*, 122 S. Ct. at 965 (stating that "the Court has left a range of permissible choices to the States, at least where the superintending federal agency has concluded that such latitude is consistent with the [Social Security Act's] aims").

Thus, federal law merely establishes *minimum* requirements for states participating in the Medicaid

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[14] *See* 42 U.S.C. § 1396a(a)(25)(A) and (H) (requiring states to take "all reasonable measures to ascertain the legal liability of third parties" and to acquire "the rights of such individual to payment by any other party"); § 1396a(a)(45) (2000) (requiring state plans to "provide for mandatory assignment of rights of payment for medical . . . owed to recipients"). *See also* 42 C.F.R. § 430.0 (2001) ("Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.").

program, beyond which states may determine how to develop and to administer the program. Assigning such broad discretion to the states is consistent with this Court's explanation that "[t]he Medicaid statute . . . is designed to advance cooperative federalism." *Blumer*, 122 S. Ct. at 975.

The *Martin* majority recognized that the federal assignment requirement "appears to set a minimum requirement for what state plans for medical assistance must contain." App. at 33. The court even acknowledged that "there is no indication that the federal assignment requirement sets a maximum that states cannot exceed." App. at 33. Even so, the court ultimately construed Minnesota's assignment language narrowly to avoid circumventing the anti-lien provision and its purpose. App. at 34-35.

In so ruling, *Martin* failed to recognize the "cooperative federalism" of the Medicaid statute. In particular, it failed to acknowledge that the federal agency has specifically affirmed the states' authority to use a variety of methods to recover its Medicaid expenditures - including lien and subrogation statutes. Instead, *Martin* applied an erroneous preemption standard to determine that Minnesota's lien law directly conflicts with Medicaid law. *See* App. at 31. Moreover, by giving the anti-lien provision absolute emphasis, *Martin* essentially amended the third party recovery and assignment provisions of the federal law, violating an important canon of statutory construction. *See, e.g., Radzanower*, 426 U.S. at 153-154.

Further, in finding that state law conflicts with the purpose of the federal Medicaid scheme, the majority minimized the primary principle of the Medicaid program: to serve as payer of last resort. *See* S. REP. No. 99-146 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312; *see also* H.R. REP. 95-393(II) (1977), *reprinted in* 1977 U.S.C.C.A.N. 3039, 3077. The majority acknowledged that third party recovery is a federal objective, App. at 27, but its holding undermined this

goal and improperly subordinated it to protection of a recipient's third party recoveries.

The majority's holding creates an enormous loophole in third party recovery cases. By simply labeling recoveries as payment for "pain and suffering" and other non-medical claims, MA recipients can effectively prevent the public from recovering medical costs from responsible third parties. See App. at 65-67. As the *Martin* dissent recognized:

> To allow recipients to shield from recovery by the state amounts labeled "pain and suffering" or other elements of damage conflicts with the clear congressional intent that Medicaid be the payor of last resort, and that the state be able to recoup its expenditures from funds to which the beneficiary was entitled before the assignment.

App. at 60. In sum, reading separate provisions of the Act narrowly and in isolation, the majority undermines the purpose of Medicaid program to the detriment of the state and federal agencies that must replenish their medical assistance funds for the benefit of future needy recipients.

CONCLUSION

For the foregoing reasons the Petition For a Writ of Certiorari should be granted.

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APPENDIX
TABLE OF CONTENTS

Martin v. City of Rochester, Minnesota Supreme Court Decision A-1

Martin v. City of Rochester, Minnesota Court of Appeals Decision A-68

Martin v. City of Rochester, District Court Order A-78

Minnesota Supreme Court denial of State's motion for rehearing A-84

42 U.S.C. § 1396a(a)25 and 45 (2000) A-85

42 U.S.C. § 1396k (2000) A-89

42 U.S.C. § 1396p (2000) A-92

Selected Code of Federal Regulations Provisions, Title 42, Subchapter C – Medical Assistance Programs (2001) A-106

Minnesota lien statute – Minn. Stat. § 256B.042 (2000) A-148

Minnesota assignment of benefits statute – Minn. Stat. § 256B.056 (2000) A-153

Minnesota's subrogation statute – Minn. Stat. § 256B.37 (2000) A-165

Senate Report No. 99-146 (1985) A-170

HCFA Publication – State Medicaid Manual Excerpt A-176

Order, dated May 13, 2002, granting of stay by Justice Thomas A-193

Order, dated May 20, 2002, vacation and denial of stay by Justice Thomas A-194

Order, dated May 23, 2002, reinstatement of stay by Justice Thomas A-195

Order, dated May 30, 2002, vacation and denial of stay by Justice Thomas A-196

HHS Departmental Appeals Board – Decision in California's Appeal A-197

HHS Departmental Appeals Board – Decision in Washington's Appeal A-214

1994 HCFA Regional Identical Letter No. 94-134 to State Medicaid Directors A-235

1996 HCFA Medicaid Director Memorandum to All State Medicaid Directors A-237

1998 HCFA Medicaid Director letter to U.S. Congressman A-244

HCFA Publication – Third Party Liability in the Medicaid Program Guide A-246

HCFA Publication – Third Party Liability – A State's Opportunity A-277

Table: Non-Exhaustive List of State Medicaid Lien Statutes A-281

Table: Excerpts of Some State Statutes Providing Medicaid
Reimbursement from Entire Settlement..... A-282

Table: Excerpts of Some State Statutes Granting Priority
to Medicaid Claims..... A-288

House of Representatives Report No. 95-393(II) (1977)..... A-291

642 N.W.2d 1
(Cite as: 642 N.W.2d 1, 2002 WL 433356 (Minn.))

H

Supreme Court of Minnesota.

Joan MARTIN, guardian ad litem for Troy HOFF,
Petitioner, Appellant,
and
State of Minnesota, plaintiff on impleader,
Respondent,
v.
CITY OF ROCHESTER, et al., Defendants.

No. C3-00-398.

March 21, 2002.
Rehearing Denied April 23, 2002.

Mother whose son who suffered brain damage in motor vehicle accident brought personal injury action as guardian ad litem to recover for son's underlying injuries, and State filed lien seeking reimbursement of medical expenses it had paid. The District Court, Olmsted County, James L. Mork, J., dismissed State's claim, and State appealed. The Court of Appeals, 615 N.W.2d 867, reversed and mother appealed. The Supreme Court, Paul H. Anderson, J., held that: (1) State medical assistance lien statute was preempted by federal law to the extent statute allowed lien to be placed on recipient's personal injury action; (2) State medical assistance assignment statute only granted State the right to be assigned recipient's claim for medical expenses; and (3) State medical assistance subrogation statute was preempted by federal law to the extent statute allowed State to assert a subrogation right against that portion of recipient's settlement that represented a recovery for claims other than claims for medical expenses.

Court of Appeals decision reversed, and action remanded to district court.

Russell A. Anderson, J., dissented and filed opinion, in which Stringer and Lancaster, JJ., joined.

West Headnotes

[1] States 18.11
360k18.11 Most Cited Cases

Whether federal law preempts state law is generally an issue of statutory construction.

[2] Appeal and Error 893(1)
30k893(1) Most Cited Cases

Statutory construction is reviewed de novo.

[3] Action 1
13k1 Most Cited Cases

"A cause of action," often referred to as a claim, is a group of operative facts giving rise to one or more bases for suing or the legal theory of a lawsuit.

[4] Property 5.5
315k5.5 Most Cited Cases

Under Minnesota law, a cause of action is personal property.

[5] States 18.3
360k18.3 Most Cited Cases

There are three distinct situations in which federal law preempts and invalidates state law; (1) when Congress

explicitly states that the federal scheme preempts any state action in the field; (2) when Congress implicitly preempts state involvement in a particular field of law because the scope of federal involvement or interest is so extensive that it fully occupies the field; and (3) conflict preemption, which takes two forms and arises when state law conflicts with federal law, either because compliance with both federal and state law is impossible or because the state law is an obstacle to the accomplishment of the purposes of the federal scheme.

[6] States 18.3
360k18.3 Most Cited Cases

Preemption of state laws is generally disfavored.

[7] States 18.5
360k18.5 Most Cited Cases

When federal laws do preempt conflicting state laws, the state laws are preempted only to the extent that they are in conflict with federal law.

[8] Social Security and Public Welfare 241.60
356Ak241.60 Most Cited Cases

[9] Statutes 188
361k188 Most Cited Cases

Fundamental principles of statutory construction require that courts give effect to the plain meaning of a statute when the language is clear.

[10] Social Security and Public Welfare 241.70
356Ak241.70 Most Cited Cases

[11] Statutes 205
361k205 Most Cited Cases

[11] Statutes 208
361k208 Most Cited Cases

Supreme Court reads and construes a statute as a whole and interprets each section in light of the surrounding sections to avoid conflicting interpretations.

[12] Statutes 206
361k206 Most Cited Cases

Supreme Court is required, when possible, to give effect to all of a law's provisions.

[13] Social Security and Public Welfare 241.70
356Ak241.70 Most Cited Cases

Federal Medicaid law requires a state to obtain an assignment of rights from the medical assistance recipient, but only for payments for medical or health care expenses. Medicaid Act, § § 1902(a)(25)(H), 1912, 1917(a)(1), as amended, 42 U.S.C.A. § § 1396a(a)(25)(H), 1396k, 1396 (a)(1).

[14] Assignments 90
38k90 Most Cited Cases

An assignment generally operates to transfer all rights possessed by the assignor and the assignor retains no interest in the right transferred.

[15] States 18.5
360k18.5 Most Cited Cases

Under conflict preemption, federal law preempts state law when compliance with both is impossible or when the state statute is an obstacle to the purposes of the federal scheme.

[16] States 18.3
360k18.3 Most Cited Cases

If a reading of a state statute requires preemption in whole or in part, Supreme Court will then look further to determine whether the statute is susceptible to another interpretation that does not raise a constitutional defect.

[17] Social Security and Public Welfare 241.70
356Ak241.70 Most Cited Cases

State medical assistance assignment statute grants to the state an assignment right to a medical assistance recipient's claims for medical care from potentially liable third parties, but not to any other claims or the recovery therefrom, when a recipient has a cause or causes of action against third parties for his injuries; though a more conventional reading of statute would give state assignment rights to all payments from third parties, such reading would require preemption by federal law, as it would interfere with federal Medicaid anti-lien provision providing that liens cannot be placed on personal property of recipients before their death. Medicaid Act, § 1917(a)(1), as amended, 42 U.S.C.A. § 1396p(a)(1); M.S.A. § 256B.056, subd. 6.

[18] Subrogation 29
366k29 Most Cited Cases

A subrogation right has the same practical effect as an assignment.

[19] Social Security and Public Welfare 241.70
356Ak241.70 Most Cited Cases

[20] Social Security and Public Welfare 241.70
356Ak241.70 Most Cited Cases

[21] Statutes 219(2)
361k219(2) Most Cited Cases

Deference to agency interpretation of a statute is called for only when there is an ambiguity in the expression of congressional intent.

[22] Social Security and Public Welfare 241.70
356Ak241.70 Most Cited Cases
(Formerly 356Ak241.115)

Minnesota Supreme Court would not defer to federal Health Care Financing Administration's (HCFA) interpretation of federal Medicaid anti-lien statute, that such statute does not bar a state from imposing a lien on a medical assistance recipient's rights to recover for other than medical care, as statute was unambiguous in providing that lien could not be placed on property of a recipient before his death. Medicaid Act, § 1917(a)(1), as amended, 42 U.S.C.A. § 1396p(a)(1).

[23] Statutes 219(1)
361k219(1) Most Cited Cases

When an agency statement does not reflect formal rules or agency adjudications, yet attempts to address an ambiguity in the law, deference to the agency's interpretation of a statute is not appropriate; such agency interpretations are only entitled to respect to the extent that those interpretations have the power to persuade.

[24] Statutes 219(6.1)
361k219(6.1) Most Cited Cases
(Formerly 356Ak241.115)

"Best Practices Guide" citing Minnesota's subrogation statute as "model legislation" and various letters from federal Health Care Financing Administration's (HCFA)

administrators to state administrators and others stating that medical assistance liens are not prohibited under federal law were not accorded deference in deciding whether federal Medicaid anti-lien statute barred state from imposing a lien on a medical assistance recipient's rights to recover for other than medical care, as such materials did not reflect formal rules or adjudications. Medicaid Act, § 1917(a)(1), as amended, 42 U.S.C.A. § 1396p(a)(1); M.S.A. § 256B.042, subd. 1.

[25] Statutes 219(1)
361k219(1) Most Cited Cases

Agency interpretations of a statute are only entitled to deference if they are reasonable.

[26] Social Security and Public Welfare 241.70
356Ak241.70 Most Cited Cases

Under harmonized federal and state law, medical assistance recipients are required to assign to the state their rights to receive payment for medical expenses from any potentially liable third parties; this assignment enables the state to acquire the recipient's property rights to this particular claim and to take independent legal action, or to be joined as a party to the recipient's action, and thus, the state can take an active role as a plaintiff in its own right and does not have to rely on the efforts of others to ensure a recovery of medical assistance expenses. Medicaid Act, § § 1902(a)(25)(H), 1912, 1917(a)(1), as amended, 42 U.S.C.A. § § 1396a(a)(25)(H), 1396k, 1396p(a)(1); M.S.A § 256B.042, subd. 1.

[27] Social Security and Public Welfare 241.70
356Ak241.70 Most Cited Cases

To the extent settlement proceeds medical assistance recipient received in settlement of personal injury action

were not a recovery of his medical expenses, such proceeds were his personal property, and as such were protected by the federal Medicaid anti-lien provision; at time of accident recipient received a "bundle of sticks" representing all of his potential rights to recover against those responsible for his injuries, in order to receive medical, assistance recipient had assigned to state his right to recover medical expenses from those responsible for his injuries and state became sole owner of recipient's right to recover those expenses, but recipient retained ownership of the remaining "sticks" in the bundle, namely his right to recover for pain and suffering, emotional distress, disability, disfigurement, loss of earnings, and loss of earning capacity. Medicaid Act, § § 1902(a)(25)(H), 1912, 1917(a)(1), as amended, 42 U.S.C.A. § § 1396a(a)(25)(H), 1396k, 1396(p)(a)(1); M.S.A § 256B.042, subd. 1.

[28] Social Security and Public Welfare 241.70
356Ak241.70 Most Cited Cases
Liens.

State was entitled to that part of personal injury settlement medical assistance recipient received that represented a recovery of his claim for medical expenses, where recipient had assigned to state his right to recover medical expenses from those responsible for his injuries, settlements with defendants included and released all of recipient's claims including claims for medical expenses, and as part of settlement state had released defendants from all further liability. Medicaid Act, § § 1902(a)(25)(H), 1912, 1917(a)(1), as amended, 42 U.S.C.A. § § 1396a(a)(25)(H), 1396k, 1396p(a)(1); M.S.A § 256B.042, subd.1.

West Codenotes

Preempted

Minn.Stat. § 256B.042, subd. 1

Minn.Stat. § 256B.37, subd. 1.

*5 Syllabus by the Court

**1 Minnesota Statutes § 256B.042 (2000), the state medical assistance lien provision, is preempted by 42 U.S.C. 1396p (1994), the federal Medicaid anti-lien provision, to the extent that it allows a lien for medical assistance paid to be placed on a medical assistance recipient's cause of action before a recipient's death.

Minnesota Statutes § 256B.056, subd. 6 (2000), the state medical assistance assignment statute, is to be construed such that "for the costs of medical care" modifies "all proceeds." When a medical assistance recipient has a cause of action against potentially liable third parties for his injuries, the medical assistance assignment statute grants to the state the right to an assignment of all claims for medical care, but does not grant an assignment right to other claims or the recovery therefrom.

Minnesota Statutes § 256B.37, subd. 1 (2000), the state's medical assistance subrogation provision, is preempted by the anti-lien provision to the extent that it allows the state to assert a subrogation right against a medical assistance recipient's claims or settlements for other than medical expenses.

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Heard, considered, and decided by the court en banc.

OPINION

PAUL H. ANDERSON, Justice.

Joan E. Martin settled a personal injury cause of action against multiple defendants on behalf of her disabled son, Troy Hoff. The state asserted a medical assistance lien against the proceeds as reimbursement for Hoff's medical expenses paid by the state through medical assistance. The state also asserted a subrogation right to the proceeds. The district court dismissed the state's claim to the proceeds, finding that the state medical assistance lien and subrogation provisions were preempted by federal law. The state appealed to the Minnesota Court of Appeals, which reversed the district court, holding that federal law did not preempt the state's lien and subrogation rights. Martin appealed to this court. We reverse.

Troy Hoff and Donald Tlougan were involved in a single-car accident on July 10, 1991, near Rochester, Minnesota. Tlougan died as a result of the accident. Hoff suffered permanent and totally disabling *6 injuries and was rendered mentally incompetent.

Hoff's mother, Joan E. Martin, sought medical assistance from the State of Minnesota on Hoff's behalf. The state began making medical assistance payments for Hoff's care on November 25, 1991. About a year and a half later, on May 23, 1993, Martin assigned to the state all of Hoff's rights to

payment for medical care from any third party liable for Hoff's injuries. Martin made the assignment as Hoff's authorized representative. [FN1]

FN 1. It is unclear from the record what legal authority Martin had to make this assignment for Hoff. Nevertheless, for purposes of this appeal, it is undisputed that Martin made a valid assignment of Hoff's rights.

**2 The state filed a public assistance lien in the Olmsted County Recorder's Office on June 21, 1993. The lien was specifically placed upon Hoff's causes of action arising out of the accident. This lien was for $267,754.50 of past medical assistance benefits paid on Hoff's behalf, and also included any future medical assistance benefits to be paid as a consequence of the accident.

Martin, as guardian ad litem for Hoff, sued Tlougan's estate, the City of Rochester, Rochester Township, and the County of Olmsted. [FN2] Martin sought recovery for past and future expenses for medical care and treatment, past and future pain and suffering, disability, disfigurement, past loss of earnings, loss of earning capacity, and other general and specific damages. Martin joined the state as an involuntary plaintiff on impleader, alleging that, as a result of the state's medical assistance lien, the state's presence was necessary for a "just adjudication of all rights." As a result of joining the state as a plaintiff impleader, Martin was able to plead a claim on behalf of the state alleging that the defendants were liable to the state for past and future expenses for medical care, treatment, sheltered living, and other general and specific damages.

FN2. Martin subsequently dismissed her action against the County of Olmsted.

After being joined as a plaintiff on impleader, the state filed an answer and cross-claims against Martin. In its answer, the state specifically denied Martin's characterization of the state as an appropriately named plaintiff and alleged that "as a lienholder on the present cause of action," it did not need to be named as a plaintiff on the pleadings. Instead, the state, in its cross-claim against Martin, relied on its lien rights under Minn.Stat. § 256B.042, subd. 1 (2000), claiming the right to reimbursement for medical expenses it paid on Hoff's behalf from any judgment, award, or settlement of Hoff's causes of action. [FN3] After filing its answer and cross-claims, the state was not significantly involved in the litigation and did not independently pursue its claim against defendants for medical expenses as pleaded by Martin on its behalf.

> FN3. The state also pleaded a second cross-claim, relying on the assignment of rights provision in the medical assistance application. However, this cross-claim only attempted to recover the no-fault insurance proceeds from Tlougan's no-fault insurer. Martin and the state later reached a settlement regarding the state's claim to the no-fault proceeds.

Nearly 6 years after commencing this action, Martin negotiated settlements with the defendants, first with the City of Rochester and then with Tlougan's estate and Rochester Township. The combined total of the settlements was $220,000. The settlement agreements encompassed all causes of action and claims.

The district court explicitly stated in its orders approving these settlement agreements *7 that it was aware of the nature and extent of Hoff's injuries, the damages claimed, the respective positions of the parties regarding liability, and the consequences of further litigation between the parties. The court found that the settlements were fair, just, and in the best interests of Hoff. The court also stated that it was

aware of a dispute between Martin and the state regarding the state's claim to part of the settlement proceeds. However, the court concluded that this dispute did not involve the settlements directly and only concerned the eventual disbursement of the balance of the settlement proceeds. The court concluded that the dispute between Martin and the state should not delay the settlement with the defendants and that the interests of Martin and the state in the settlement proceeds could be protected by depositing the balance of the proceeds in an interest-bearing account with the court administrator. In compliance with the order of the court approving each settlement, Martin and the state released all three defendants from further liability and stipulated to a dismissal with prejudice on their claims. It is unclear from the record what claims were part of the settlement and how, if at all, the settlement proceeds were allocated among the respective claims.

**3 After the settlements with the three defendants had been agreed upon, Martin and the state pursued their separate dispute regarding the state's cross-claim. [FN4] Specifically, the state asserted that its medical assistance lien entitled it to obtain out of the remaining settlement proceeds $58,561.82 as reimbursement for the over $600,000 it had paid by that time for Hoff's medical care. [FN5]

FN4. Martin filed a motion to dismiss the state's cross-claim after the settlement with the City of Rochester had been approved, but before the settlement with Rochester Township and the estate of Donald Tlougan had been approved by the court, although it appears that a dollar amount had been agreed upon.

FN5. Although the state had paid over $600,000 for Hoff's medical care, the state only sought to recover $58,561.82 of the settlement proceeds. State law requires that reasonable costs of collection, including attorney

> fees, be deducted first from a Medicaid recipient's recovery and the full amount of medical assistance paid to the recipient be deducted second. Minn.Stat. 256B.042, subd. 5 (2000). In any case, under Minnesota's third-party recovery system, the recipient must receive at least one-third of the net recovery after attorney fees and other collection costs. *Id.*

Martin filed a motion to dismiss the state's claim, arguing that federal law prohibited the state from placing a lien on a medical assistance recipient's property. Martin argued that the settlement proceeds were solely Hoff's property because the assignment to the state of Hoff's rights to medical expenses left Martin with no power to collect or sue for medical expenses on Hoff's behalf. Therefore, Martin asserted that the settlement proceeds were solely Hoff's property because the settlement was made only on Hoff's remaining personal injury claims, i.e., damages for pain and suffering, disfigurement, disability, emotional distress, loss of earnings, and loss of earning capacity, but not medical expenses.

In response to Martin's motion, the state argued (1) that the federal anti-lien statute does not apply to third-party recoveries, (2) that the lien does not attach to the cause of action but instead to the proceeds, and (3) that proceeds are the property of the liable third parties. Additionally, the state contested Martin's argument on the effect of the assignment, arguing that the assignment did not deprive Martin of the ability to sue and collect for medical expenses. The state asserted that the assignment left both Martin and the state *8 with the ability to pursue a recovery of medical expenses. Therefore, the state argues, the settlement included a recovery for medical expenses. Moreover, in its argument to the district court, the state did not assert that part of the settlement included the state's independent claim as pleaded by Martin. At this point in the proceedings, the state for the

first time raised a subrogation claim under Minn.Stat. § 256B.37 (2000) for the medical assistance paid.

The district court granted Martin's motion to dismiss the state's claim to any of the settlement proceeds. The court found that, as a result of the assignment in the medical assistance application, neither Martin nor Hoff had any right to recover medical expenses from the defendants. The court then found that the settlement proceeds were Hoff's sole and exclusive property. The court further found that, because federal law bars imposition of a lien on any of Hoff's property during his lifetime and state lien laws permit a lien against Hoff's property, state lien laws conflicted with federal laws and thus were preempted. The court also rejected the state's subrogation claim on the grounds it was also prohibited by the federal anti-lien statute and because it was not timely asserted.

Although the foregoing proceedings were at times confusing, the final outcome in the district court can best be summarized as follows. The court found that Hoff's right to recover medical expenses was completely assigned to the state, leaving Martin, as Hoff's guardian, with no right to collect for medical expenses. Hoff's remaining rights to recover included all of his claims for personal injury damages except for medical expenses. Martin settled all of Hoff's remaining claims arising out of the accident against the three defendants for $220,000. The state released the three defendants from further liability for its claims, apparently relying only on its lien and subrogation rights to recover medical expenses paid on Hoff's behalf. The court then found that the state was not entitled to any of the settlement funds. The court concluded that the state's lien and subrogation rights were preempted by federal law.

**4 The combined result of the settlement agreements, releases, and the district court's order left the state without

the ability to recover its medical expenses paid on Hoff's behalf. That is to say, the state could not collect anything, either directly through a cause of action against the defendants or indirectly through the use of liens or subrogation against the settlement proceeds. [FN6]

FN6. The state is also prohibited from suing a medical assistance recipient directly. *See* 42 U.S.C. § 1396p(b)(1) 1994).

The state appealed, arguing that the federal anti-lien provision preempts neither the state's medical assistance lien statute nor the state's subrogation statute. The court of appeals agreed with the state and reversed the district court, concluding that Minnesota's medical assistance statute does not conflict with the federal Medicaid statutory scheme because compliance with both the state and federal provisions was possible. The court of appeals concluded that federal law therefore did not bar the state from placing a lien on the settlement proceeds. The court of appeals also concluded that the third-party settlement was subject to the state's subrogation claim. Martin then appealed to this court.

I.

[1][2] This case presents three legal questions. The questions are whether *9 Minnesota's medical assistance lien, assignment, and subrogation statutes are preempted by the federal anti-lien statute. Whether federal law preempts state law is generally an issue of statutory construction. *Pikop v. Burlington N.R.R. Co.*, 390 N.W.2d 743, 748 (1986). Statutory construction is reviewed de novo. *Am. Family Ins. Group v. Schroedl*, 616 N.W.2d 273, 277 Minn.2000).

A. *Statutory Background*

For an understanding of the legal issues in this case, it is first necessary to understand the relevant Medicaid statutes. Medicaid, enacted in 1965 as Title XIX of the Social Security Act, is a publicly funded program to ensure medical care to certain individuals who lack the resources to cover the costs of essential medical services. 42 C.F.R. § 430.0; *see* Norwest Bank of N.D., N.A. v. Doth, 159 F.3d 328, 331 (8th Cir.1998). Medicaid was intended to be the payor of last resort. *See* H.R. Conf. Report No. 99-453, at 542 (1985). Medicaid is jointly funded by the federal and state governments. 42 C.F.R. § 430.0. Each state administers its own program within federally mandated requirements. *Id.* On the federal level, the Health Care Financing Administration (HCFA) is responsible for administering the Medicaid program.

[3][4] The focus of our analysis is on the relationship between federal and state laws addressing the government's right to recover funds it has expended for medical care under the Medicaid program. The most relevant federal statute is an anti-lien provision prohibiting states from imposing a lien on property of a Medicaid recipient because of medical assistance paid. 42 U.S.C. § 1396p(a)(1) (1994) ("[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid * * *."). Despite this federal prohibition, a Minnesota statute grants to the state lien rights for the cost of care arising from the injuries which lead to the need for medical assistance. Minn.Stat. § 256B.042, subd. 1 (2000). More specifically, the Minnesota statute provides in relevant part:

> **5 When the state agency provides, pays for, or becomes liable for medical care, it shall have a lien for the cost of the care upon *any and all causes of action* or recovery rights under any policy, plan, or contract providing benefits for health care or injury, which accrue to the person to whom the care was furnished, or to the person's legal representatives, as a result of the illness or injuries which necessitated the medical care.

Id. (emphasis added). The statute specifically directs that a lien be placed on a cause of action or recovery rights. A cause of action, often referred to as a claim, is "[a] group of operative facts giving rise to one or more bases for suing" or "[the] legal theory of a lawsuit." Black's Law Dictionary 214 (7th ed.1999). [FN7] Under Minnesota law, a cause of action is personal property. [FN8] *See State v. Royal Mineral Ass'n*, 132 Minn. 232, 236, 156 N.W. 128, 130 (1916) ("[T]he term 'credits,' as used in the taxing statutes, embraces only choses in action which are in their nature personal property."); *Mattson v. Minnesota & N. Wis. R.R.*, 95 Minn. 477, 488, 104 N.W. 443, 448 (1905) (holding that the right to ***10** pursue damages for personal injuries is a property right); *see also* Minn.Stat. § 550.37, subd. 22 (2000) (listing "[r]ights of action for injuries to the person" as exempt property).

> FN7. *See also* A Dictionary of Modern Legal Usage 140 (Bryan A. Garnered., 2d ed.1995) (defining cause of action as "a group of operative facts, such as a harmful act, giving rise to one or more rights of action").
>
> FN8. For purposes of the anti-lien provision, HCFA defines property as "the homestead and all other personal and real property in which the recipient has a legal interest." 42 C.F.R. § 433.36(b).

In addition to the anti-lien provision, federal law also mandates that a state's medical assistance plan require that medical assistance recipients assign to the state the right to receive payments for medical expenses from third parties liable for payment of those expenses. 42 U.S.C. § 1396k(a) (1994). [FN9] Minnesota's medical assistance plan includes such an assignment requirement, although it arguably requires assignment of more rights than the federal provision. Minn.Stat. § 256B.056, subd. 6 (2000). [FN10]

FN9. The federal assignment requirement reads as follows:

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall--

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required--

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party.

42 U.S.C. § 1396k(a).

FN10. The state assignment provision reads as follows:

To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person or the person's spouse from any third person liable for the costs of medical care for the person, the spouse, and children. The state agency shall require from any applicant or recipient of medical assistance the assignment of any rights to medical support and third party payments. * * * By signing an application for medical assistance, a person assigns to the department of human services all rights the person may have to medical support or payments for medical expenses from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in * * * obtaining third party payments.

Minn.Stat. § 256B.056, subd. 6.

It is apparent that there is a conflict between the state lien and assignment provisions and the federal requirements. Despite the federal anti-lien provision, state law gives the state a lien on a medical assistance recipient's causes of action and recovery rights. Also, despite the limited scope of the federal assignment of rights requirement, state law can be read to require that medical assistance recipients, as a condition of eligibility, assign to the state more rights than the federal provision requires. *Compare* 42 U.S.C. § 1396k *with* Minn.Stat. § 256B.056, subd. 6. In addition, the state is subrogated to any rights under a recipient's cause of action arising out of an occurrence necessitating medical assistance--although, at first glance, this subrogation provision does not run afoul of any federal restrictions. Minn.Stat. § 256B.37, subd. 1 (2000).

B. *Preemption*

[5][6][7] Because of the conflict between the federal and state provisions, we must answer the question whether the federal provisions supersede the state statutes. To do so, we need to examine the law of federal preemption. There are three distinct situations in which federal law preempts and invalidates state law. *Pikop*, 390 N.W.2d at 748. First, state law is preempted when Congress explicitly states that the federal scheme preempts any *11 state action in the field. *See Jones v. Rath Packing Co.*, 430 U.S. 519, 525, 97 S.Ct. 1305, 51 L.Ed.2d 604 (1977). The second arises when Congress implicitly preempts state involvement in a particular field of law because the scope of federal involvement or interest is so extensive that it fully "occupies the field." *See, e.g., Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516, 112 S.Ct. 2608, 120 L.Ed.2d 407 (1992); *Fidelity Fed. Sav. & Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 153, 102 S.Ct. 3014, 73 L.Ed.2d 664 (1982); *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230, 67 S.Ct. 1146, 91 L.Ed. 1447 (1947). The final type of preemption,

"conflict preemption," takes two forms and arises when state law conflicts with federal law, either because compliance with both federal and state law is impossible or because the state law is an obstacle to the accomplishment of the purposes of the federal scheme. *See* Fla. Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132, 142-43, 83 S.Ct. 1210, 10 L.Ed.2d 248 (1963); *Hines v. Davidowitz*, 312 U.S. 52, 67, 61 S.Ct. 399, 85 L.Ed. 581 (1941). Preemption of state laws is generally disfavored. *See* Cipollone, 505 U.S. at 516, 518, 112 S.Ct. 2608; *Forster v. R.J. Reynolds Tobacco Co.*, 437 N.W.2d 655, 658 Minn.1989). When federal laws do preempt conflicting state laws, the state laws are preempted only to the extent that they are in conflict with federal law. *Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474, 476, 116 S.Ct. 1063, 134 L.Ed.2d 115 (1996); *De Canas v. Bica*, 424 U.S. 351, 357-58 n. 5, 96 S.Ct. 933, 47 L.Ed.2d 43 (1976); *Forster*, 437 N.W.2d at 658.

**6 [8] Congress specifically permits state action regarding Medicaid; in fact, it requires that a participating state's Medicaid plan conform to federal requirements. *Schweiker v. Gray Panthers*, 453 U.S. 34, 37, 101 S.Ct. 2633, 69 L.Ed.2d 460 (1981); *see also* 42 U.S.C. § 1396a(a) (1994 & Supp. V 1999). Thus, there is no explicit or implicit federal preemption of the field. Instead, the conflict between the federal and state provisions requires a determination that preemption will apply here only if state law conflicts with specific federal Medicaid law or is an obstacle to federal Medicaid purposes. To make this determination, we first must compare the federal anti-lien provision with the state lien provision, then compare the federal and state assignment provisions with each other, and, finally, compare the federal anti-lien and state assignment provisions. Before making such comparisons, it is important to have a more complete description of the federal Medicaid scheme.

1. *The Federal Law*

The federal anti-lien provision ensures that property of a Medicaid recipient not be depleted during his life by a state seeking reimbursement for medical assistance paid. At the same time, the federal assignment and third-party recovery provisions enable a state to recover, to the extent of third-party liability, amounts the state has paid on behalf of Medicaid recipients. These provisions may be in conflict; therefore, our first step is to examine and seek to harmonize the federal law.

[9][10] Fundamental principles of statutory construction require that courts give effect to the plain meaning of a statute when the language is clear. *See, e.g.*, *Robinson v. Shell Oil Co.*, 519 U.S. 337, 340, 117 S.Ct. 843, 136 L.Ed.2d 808 (1997); *see also* Minn.Stat. § 645.16 (2000); *Correll v. Distinctive Dental Servs., P.A.*, 607 N.W.2d 440, 445 (Minn.2000). The state argues that the federal anti-lien provision clearly does not apply to third-party recoveries. Alternatively, the state argues that if we conclude the anti-lien provision is ambiguous, we should defer to clarifying ***12** agency interpretations under the doctrine articulated in *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). But we conclude the federal anti- lien provision is unambiguous. It unequivocally provides that "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid * * *." 42 U.S.C. § 1396p(a) (1). [FN 11] Further, there is no indication in the statute's language that this anti-lien provision does not apply to third-party recoveries. The provision means exactly what it says--prior to his death, no lien may be placed on the property of a medical assistance recipient for recovery of medical assistance paid. Therefore, we will give effect to the plain meaning of the federal anti-lien provision. [FN 12]

FN 11. There are several exceptions, none of which apply to these facts. *See, e.g.*, 42 U.S.C. § 1396p(a)(1)(A), (B).

FN 12. The dissent claims that by looking first and foremost at the anti-lien provision instead of construing all provisions together, we overlook a construction that avoids preemption. However, given its broad scope and plain language, the federal anti-lien statute is and must be the beginning point of our analysis. There is little ambiguity about "[n]o lien may be imposed." Further, we thoroughly consider and give effect to limitations in companion provisions regarding payment for "health care" and "medical care" and the nature of the property assigned. We must give effect to the statute as a whole, but cannot ignore the plain import of the broad anti-lien provision.

[11][12] We read and construe a statute as a whole and "interpret each section in light of the surrounding sections to avoid conflicting interpretations." *Schroedl*, 616 N.W.2d at 277; *see also United States v. Morton*, 467 U.S. 822, 828, 104 S.Ct. 2769, 81 L.Ed.2d 680 (1984). Further, we are required, when possible, to give effect to all of a law's provisions. *See Duncan v. Walker*, 533 U.S. 167, 121 S.Ct. 2120, 2125, 150 L.Ed.2d 251 (2001); *see also* Minn.Stat. 645.16. We are mindful of these requirements as we next seek to harmonize the plain meaning of the anti-lien provision with other federal provisions.

**7 There are two other significant federal Medicaid requirements regarding a state's ability to recover medical assistance paid that must be construed in concert with our interpretation of the anti-lien provision. The first of these is the federal law that requires states to obtain from recipients, as a condition of eligibility for medical assistance, an assignment of rights to payment for medical care. 42 U.S.C. §

1396k. The specific provision requires a medical assistance recipient to "assign the State any rights, of the individual * * * to payment *for medical care* from any third party." 42 U.S.C. § 1396k (emphasis added).The second requirement directs states to recover the cost of care from potentially liable third parties. *See* 42 U.S.C. 1396a(a)(25)(H) (Supp. V 1999. The third-party recovery provision provides

> that to the extent that payment has been made under the State plan *for medical assistance* in any case where a third party has a legal liability to make payment *for such assistance,* the State has in effect laws under which, to the extent that payment has been made under the State plan *for medical assistance for health care items or services* furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party *for such health care items or services.*

42 U.S.C. 1396a(a)(25)(H) (emphasis added).

[13] Both of these provisions specifically refer to payments for medical or health ***13** care. The required assignment of rights under federal law is for payment from any third party *for medical care* only. Similarly, a state's right to recover from third parties is specifically limited under federal law to payment *for health care items or services* only. [FN13] Thus, federal law requires a state to obtain an assignment of rights from the medical assistance recipient, but only for payments for medical or health care expenses.

> FN 13. The dissent reads the third party recovery provision such that the final clause "for such health care items or services" refers to what the state has paid for and acts only as a limitation on the *amount* of the state's recovery, and not as a limitation on the character of the recovery. The dissent's interpretation is undercut by the plain language of the provision and is inconsistent with the rest of the federal Medicaid scheme. In particular, the reference in the third-party recovery provision to the

> state having "acquired the rights of such individual" can only refer to the federally required assignment which, by its plain meaning, is also limited to an assignment of payment for medical care. Thus, when interpreted according to its plain language and as consistent with the federal scheme, the only fair reading of the third-party recovery provision limits the state's recovery to third-party payments *for medical or health care.*

[14] The right assigned to the state is the medical assistance recipient's right to recover medical expenses from third parties liable for payment of those expenses. [FN 14] An assignment generally operates to transfer all rights possessed by the assignor and the assignor retains no interest in the right transferred. *Marquette Appliances, Inc. v. Econ. Food Plan, Inc.*, 256 Minn. 169, 173, 97 N.W.2d 652, 655 (1959). By assigning the right to recover medical expenses, the Medicaid recipient no longer owns that right of recovery, i.e., the right is no longer the property of the recipient. Therefore, state enforcement of the assignment for medical expenses does not violate the anti-lien provision because recovery under the assignment does not operate on the property of the recipient. Moreover, this assignment allows the state to follow the federal directive to pursue third parties that may be liable for the costs of medical care. Although the state may not file a lien, the assignment does give the state the ability to pursue the third parties directly.

> FN 14. Accordingly, the federally required assignment encompasses the right to payments from potentially liable tortfeasors as well as insurers or others liable for the payments but who are not liable for the underlying injuries.

**8 The foregoing analysis convinces us that there is no need to engage in an arduous or belabored statutory construction to harmonize the three federal statutes. Taking

notice of the plain meaning of each is sufficient to achieve harmony. The anti-lien provision protects the personal property of a medical assistance recipient--here, Hoff's cause of action--from a state's effort to recover for medical expenses. The assignment transfers to the state the recipient's right to recover medical expenses, and therefore the ability to pursue directly potentially liable third parties for medical assistance expenses paid. The anti-lien provision protects all of a recipient's nonassigned rights to recover. The recovery provision, on the other hand, requires that the state pursue the third parties for medical expenses paid by the state, and the state does so under the assignment. The result is that the anti-lien provision operates in harmony with other federal Medicaid provisions and gives effect to all of the provisions. [FN15]

FN 15. The dissent asserts that we are interpreting the statute as a whole, yet reading out a federal requirement. What we have done is look to the plain meaning of the federal statutes to determine whether they operate in harmony with each other. The dissent argues that we have failed to adequately address the requirement that states recoup their expenditures out of proceeds from third parties, but by doing so misconstrues the federal requirement. As noted above, states are required to recover their expenditures from medical assistance recipients, but only from third party payments for *medical care.* 42 U.S.C. 1396a(a)(25)(H) (referring specifically to "health care items or services"). The dissent correctly cites the "for medical care" language as contained in the statute, but then ignores this language in its analysis. We conclude that it is impossible to correctly construe the federal requirement without focusing on this language.

The dissent also states that our analysis loses sight of the presumption against preemption of state law. We acknowledge a presumption against preemption of state

law. *See, e.g.*, *Bldg. & Constr. Trades Council of Metro. Dist. v. Associated Builders & Contractors of Mass./R.I., Inc.*, 507 U.S. 218, 224, 113 S.Ct. 1190, 122 L.Ed.2d 565 (1993). But we cannot completely disregard the plain meaning of a federal statute because of a presumption against the preemption of state laws. Were the opposite to be true, the presumption against preemption of state law would override our obligation to adhere to the plain meaning of federal statutes, federal preemption of state law under conflict preemption would never occur, and the category would be irrelevant. If plain meaning can be ignored, courts would almost always be able to find an interpretation that prevents preemption.

***14** The three federal statutes reflect dual federal objectives: first, protection of the recipient's limited assets from encroachment by the state for reimbursement for medical expenses paid; second, requiring recovery and reimbursement from third parties liable for the recipient's medical expenses that were paid by Medicaid. [FN16] The statutes reflect these objectives by insulating the recipient's property from the state's recovery through the anti-lien provision, while at the same time requiring assignment to the state of the recipient's right to collect from third parties liable for the costs of medical care paid by the state and by requiring the state to exercise its recovery rights. [FN 17]

FN 16. The dissent inordinately focuses on the third-party recovery aspect of the Medicaid system and fails to adequately address the federal purpose and objective of protecting a medical assistance recipient's property during his lifetime. In our analysis, we must confront all of the purposes and objectives of the federal Medicaid system.

FN 17. The dissent opines that our interpretation of the assignment statute frustrates the purpose of the

Medicaid program and would "eviscerate Congress's clearly expressed intention that these funds be repaid," quoting language from Norwest Bank of North Dakota, N.A. v. Doth, 159 F.3d 328, 333 (8th Cir.1998). In doing so, the dissent exaggerates the impact of our opinion on the state's ability to recover. Further, in an effort to buttress its position, it takes Doth out of context. Doth addressed medical assistance recipients' ability to place third-party settlement proceeds in supplemental needs trusts (SNT) ahead of the state's medical assistance liens. Funds in SNTs remain inaccessible to the state until the recipient's death. Doth, 159 F.3d at 331-32. Doth dealt with a situation in which recipients were attempting to place the *entire* recovery from third-party tortfeasors into a SNT, whereas this case only defines the limits of the state's ability to recover. In Doth, the court was addressing a very different and more drastic limitation on states' ability to recover. Furthermore, Doth specifically declined to address the validity of the state's liens, and did not determine whether the liens were able to be satisfied out of the entire settlement, or only that part attributable to medical expenses. Id. at 334. Importantly, Doth did not mention the anti-lien provision at all.

It is critical to note that the federal scheme reflects the concept that the assigned right to recover for medical expenses is no longer the property of the medical assistance recipient and therefore the anti-lien provision does not prohibit a state from pursuing recovery under this assigned right. Essentially, at the time of an accident, the injured party acquires in tort one or more rights of action or claims against those responsible for the injuries. These rights of action or claims can be ***15** likened to a "bundle of sticks." *See* United States v. Ben-Hur, 20 F.3d 313, 317-18 7th Cir.1994) (stating that property rights are likened to "bundle of sticks," each stick separately alienable); In re Nelson, 92 B.R. 837, 842

(Bankr.D.Minn.1988) (reflecting the implicit concept that property rights are divisible). As a condition of receiving medical assistance from a state, a medical assistance recipient assigns to the state one stick from that bundle-- the specific claim to recover medical expenses from those responsible for the injuries. At this point, the state becomes the sole owner of the claim against any third parties for medical expenses. But the recipient retains ownership of the remaining sticks in the bundle--that is to say, the claims for pain and suffering, emotional distress, disability, disfigurement, loss of earnings, and loss of earning capacity. To the extent that any settlement with the responsible third parties is for this larger bundle of sticks (the original tort action minus the claim for medical care), the settlement proceeds are the recipient's personal property, and as such are protected by the federal anti-lien provision.

**9 The dissent expresses concern about our willingness to recognize these separate claims and cites a medical assistance eligibility case, *In re Welfare of K.S.*, as support for its analysis. In *K.S.*, we attempted to determine the availability of certain assets for purposes of medical assistance eligibility. 427 N.W.2d 653, 658-59 (Minn. 1988). Specifically, we addressed whether the purpose for which a tort settlement fund was received affected the fund's availability for medical assistance eligibility. *Id* at 659. We do not disagree with the holding in *K.S.*, but do not see its relevance to the case before us. [FN18] In *K.S.*, we concluded that the state medical assistance subrogation provision, Minn.Stat. § 256B.37, indicated a clear legislative intent that the availability of a settlement fund for medical assistance eligibility purposes does not depend on the purpose for which the settlement was received. *K.S.*, 427 N.W.2d at 659. We also noted that the medical assistance lien provision indicated a legislative intent to place the burden of medical assistance on the tortfeasor and therefore on the tort recovery. *Id.* at 660. However, because the issue before the

court in K.S. was eligibility for medical assistance and not the validity of a medical assistance lien, we did not address the federal anti-lien provision and its impact on state medical assistance laws. As developed in detail below, the federal anti-lien provision is critical to the resolution of the case before us.

> FN 18. We note the impact of our holding in K.S. may have been changed in light of the availability of a SNT. In 1993, Congress passed the Omnibus Budget Reconciliation Act of 1993, which provides that a SNT may be created for the benefit of a disabled individual if the assets of the trust are to be transferred to the state upon the death of such individual. 42 U.S.C. 1396p(d)(4)(1994). The assets of such a properly created SNT are not considered for purposes of determining eligibility for medical assistance. *Id.* Minnesota currently recognizes the validity of SNTs created under federal law. Minn.Stat. § 501B.89, subd. 3 (2000).

2. *State Medical Assistance Lien*

Having set forth the federal law, we must now juxtapose the federal anti-lien provision and Minnesota's medical assistance lien to determine whether compliance with both is impossible or whether the state law is an obstacle to accomplishment of the purposes of the federal Medicaid scheme. The state lien provision gives the state a lien for the cost of care "upon any and all causes of action" which accrue to the medical assistance recipient as a result of the injuries that necessitated the *16 medical care. Minn.Stat. § 2568.042, subd. 1. But as previously noted, these causes of action or claims are the personal property of the medical assistance recipient. *See Royal Mineral Ass'n,* 132 Minn. at 236, 156 N.W. at 130; *see also Mattson,* 95 Minn. at 488, 104 N.W. at 448. Therefore, the state medical assistance lien provision appears

to conflict with the federal anti-lien provision and should be subjected to a preemption analysis.

[15] Under conflict preemption, federal law preempts state law when compliance with both is impossible or when the state statute is an obstacle to the purposes of the federal scheme. *See Fla. Lime & Avocado Growers*, 373 U.S. at 142-43, 83 S.Ct. 1210; *Hines*, 312 U.S. at 67, 61 S.Ct. 399. Here, the federal anti-lien statute prohibits placing a lien upon a medical assistance recipient's personal property before the recipient's death. This provision can coexist with the federal assignment provision because the assignment removes from the property of the recipient his claim for medical care. Yet the state's medical assistance lien provision allows a lien to be placed on a variety of claims that are still the recipient's personal property. This result is in direct conflict with the federal anti-lien provision. Therefore, we conclude that compliance with both provisions is not possible because the federal law prohibits exactly what the state law allows.

**10 Having concluded that the state lien provision is in conflict with federal law, we are now presented with two options for the ultimate fate of the state law. One option is to hold that the state law is preempted entirely. However, preemption is disfavored, and a state law should be preempted only to the extent that it is in conflict with federal law. *See Weber v. Heaney*, 995 F.2d 872, 875 (8th Cir.1993); *Forster*, 437 N.W.2d at 658. But given the clear and broad prohibition of the "no lien" language in the federal anti-lien provision, we are not able to ascertain an appropriate limiting construction to the state's medical assistance lien provision. Therefore, we hold that section 256B.042, Minnesota's medical assistance lien statute, is preempted to the extent that it allows a lien for medical assistance paid to be placed on a medical assistance recipient's cause of action before a recipient's death.

II.

Having held that the state cannot place a lien on a medical assistance recipient's personal property on account of medical assistance paid before the recipient's death, we must determine whether the state can otherwise recover under the assignment obtained under section 256B.056, subd. 6, Minnesota's assignment statute. To make this determination, we must juxtapose federal Medicaid law and Minnesota's assignment statute to determine whether compliance with both is also impossible or whether the state law is an obstacle to accomplishment of the purposes of the federal Medicaid scheme.

The Minnesota assignment statute, like the federal assignment law, requires an assignment of the medical assistance recipient's rights to medical expenses. The specific assignment language reads as follows:

> The state agency shall require from any applicant or recipient of medical assistance the assignment of any rights to medical support and third party payments. * * * By signing an application for medical assistance, a person assigns to the department of human services all rights the person may have to medical support or payments for medical expenses from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in *17 establishing paternity and obtaining third party payments.

Minn.Stat. § 256B.056, subd. 6. It also provides that an applicant must agree to apply "*all proceeds* received or receivable by the person * * * from any third person liable for the costs of medical care * * *." *Id.* (emphasis added).

[16] In the "all proceeds" sentence, reading the clause "for the costs of medical care" to modify "any third person liable" appears to be the more conventional reading of the language of the statute; therefore, we will first proceed to analyze this

interpretation of the language. If under this reading preemption is not required, our analysis of this provision will be complete. However, if we conclude that this reading requires preemption in whole or in part, we will then look further to determine whether the, statute is susceptible to another interpretation that does not raise a constitutional defect. *See* Hince v. O'Keefe, 632 N.W.2d 577, 582 (Minn.2001) (explaining that we are under an obligation to interpret our statutes to avoid constitutional defects).

**11 Under the foregoing construction of the statute, when "for the costs of medical care" is read to modify "any third person liable," "all proceeds" is not limited to payments received or receivable for medical care and includes *any* payments ("all proceeds") from third parties who are liable for medical care. Thus, the assignment provision appears to give the state an assignment for more than what the federal law mandates because the federal law only requires that states obtain an assignment of the medical assistance recipient's *right to recover medical expenses* from liable third parties. However, the state's ability to recover medical expenses paid is not limited to a recovery only from a recipient's right to recover for medical expenses. Therefore, it appears that the statute may be broader than federal law and should be subjected to a preemption analysis.

While Minnesota's assignment provision appears broader than the federal requirement, this does not mean that the statute and federal law are in conflict per se. The federal assignment requirement appears to set a minimum requirement for what state plans for medical assistance must contain and for what recipients must assign, but there is no indication that the federal assignment requirement sets a maximum that states cannot exceed. Unlike the anti-lien provision, the assignment provision contains no explicit prohibition or restriction. So compliance with both the federal assignment requirement and the state assignment

requirement is possible; the state provision just goes above and beyond what the federal provision absolutely requires. However, the breadth of the state assignment may implicate the second form of conflict preemption if it interferes with the purposes of the federal Medicaid scheme.

Under the state assignment provision, the state is not only assigned the recipient's right to payments for medical care, but is also assigned the rights to "all proceeds" from third parties liable for medical care. The implication of the "all proceeds" language is that the state has a right to *any* payment made to a medical assistance recipient by a third party liable for the recipient's medical care--including settlement proceeds from a cause of action exclusive of medical expenses. The rights to these other causes of action are not required to be assigned by the federal assignment provision, and as we have already concluded, these nonassigned rights to recover or claims *are* protected by the anti-lien provision. The state cannot place a lien on this property during the recipient's life because it is personal property of the recipient.

***18** Despite the foregoing restriction, the state's broad assignment right allows the state to take by an assignment what is protected by the anti-lien provision. Allowing the state to expand the range of the required assignment to defeat the anti-lien provision interferes with the federal scheme. In essence, it circumvents the anti-lien provision and eliminates the efficacy of that provision's protection. The purpose of the anti-lien provision is to protect the recipient's limited assets, including nonassigned rights to recover, and the assignment statute frustrates this purpose. Therefore, we conclude that under the foregoing reading of Minnesota's assignment statute, the statute is broader than its federal counterpart and interferes with the purposes of the federal Medicaid scheme generally and the anti-lien provision in particular.

**12 Accordingly, we conclude that under this construction the statute is preempted in part. To the extent that the state assignment provision gives the state rights to more than the recipient's claim for medical expenses, it should be preempted by federal law. However, to the extent that the state assignment mirrors the federal assignment provision and requires that medical assistance recipients assign to the state all rights to payment for medical care from third parties liable for the injuries that necessitated medical assistance, the state assignment provision should not be preempted. [FN19]

FN 19. The dissent implies that our decision impairs the right of a medical assistance recipient to transfer his/her causes of action by assignment. But this misses the point. We acknowledge that medical assistance recipients have the right and thus are *able* to assign any and all of their causes of action or claims to the state (or, for that matter, to anyone else). However, there is no *obligation* under federal law to assign more than a claim for medical care. The problem here is that the dissent's interpretation of the state assignment provision transforms a right to transfer into an obligation to transfer more than what the federal law requires. Such an expansive obligation runs headlong into the federal anti-lien provision.

Alternative Interpretation

As noted earlier, we are under an obligation to interpret our statutes to avoid constitutional defects. *Hince*, 632 N.W.2d at 582. Therefore, if the state assignment provision is susceptible to an alternative interpretation that allows it to operate in harmony with the federal Medicaid scheme and not be preempted, we must apply that interpretation. Here, the state medical assistance assignment provision differs from the federal mandate in one important respect--the "all

proceeds" sentence. It reads, "[t]o be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person or the person's spouse from any third person liable for the costs of medical care for the person, the spouse, and children." Minn.Stat. § 256B.056, subd. 6. The "all proceeds" sentence is apparently a state innovation and not required by the federal law. [FN20]

> FN20. Otherwise, the state assignment provision parallels the federal requirements of 42 U.S.C. § § 1396a(a)(25)(H) and 1396k(a). To the extent that it appears to give rights against more than recovery for medical care, it is an innovation; to the extent that it has a retroactive effect--as an award of the proceeds (for medical care) that may have been paid out *before* a settlement--it does conform to section 1396a(a)(25)(H).

Our first interpretation of this statute would give the state the right to all proceeds received from liable third parties. Recovery under this interpretation is not limited to proceeds for medical care. But this section is susceptible to an alternative interpretation. The clause "for the costs ***19** of medical care" can be read to modify either "all proceeds" or "from any third person liable."

[17] If we interpret the statute such that "for the costs of medical care" modifies "all proceeds," we can avoid an interpretation that necessitates preempting part of the state statute. When we read the statute in this way, it gives the state no more rights against the recipient than the federal requirement. [FN21] Under this interpretation of the statute's language, the state has assignment rights to all proceeds for *medical care,* but does not have rights in any other part of a recovery. Because our canons of interpretation instruct us to interpret statutes to avoid constitutional problems, we conclude that "for the costs of medical care" modifies "all

proceeds." Therefore, we hold that when a medical assistance recipient has a cause or causes of action against potentially liable third parties for his injuries, the medical assistance assignment statute grants to the state an assignment right to all claims for medical care, but it does not grant an assignment right to any other claims or the recovery therefrom.

> FN21. However, the "all proceeds" language may operate to give the state rights in any recovery made before the assignment--a retroactive effect. This goes beyond the requirement in the federal assignment provision, but it gives effect to the third-party recovery requirement in § 1396a(a)(25)(H).

**13 This limited interpretation of the statute allows the federal scheme to function appropriately. The state assignment provision is now functionally equivalent to the federal assignment provision. The state has an assignment of rights limited to the right to medical expenses and may no longer pursue "all proceeds" from third parties. Effectively, the state is entitled to an assignment of the recipient's right to recover for medical expenses against all third parties that are potentially liable for the injuries that necessitated medical assistance.

III.

The next question before this court is whether the statute granting the state a subrogation right is preempted by federal law. [FN22] In addition to asserting statutory lien rights, the state also asserts a subrogation right to the settlement proceeds under Minn.Stat. § 256B.37, subd. 1. [FN23] This provision gives the state a subrogation right "to the extent of the cost of medical care furnished" to any rights the medical assistance recipient may have under the cause of action "arising out of an occurrence that necessitated the

payment of medical assistance." *Id.* The scope of the subrogation right is broader than the rights given to the state in the federal medical assistance assignment provision. ***20** The subrogation right is not limited to claims for medical expenses. In fact, the subrogation right specifically includes "all portions of the cause of action, notwithstanding any settlement allocation." *Id.* As we interpret the subrogation provision, it allows the state a subrogation right for the cost of care against any recovery on a cause of action arising out of the incident that necessitated medical assistance, even if the recovery also included claims other than for medical expenses.

FN22. Martin asserts that the state waived its subrogation claim because it was not timely filed. Upon review of the record, we conclude that the issue was properly raised before the district court. *See* Barton v. Moore, 558 N.W.2d 746, 749 (Minn. 1997) (explaining that Minnesota is a notice pleading state); *Anderson v. Rengachary*, 608 N.W.2d 843, 852 (Minn.2000) (Gilbert, J., concurring in part and dissenting in part).

FN23. In pertinent part, the subrogation statute provides:

Upon furnishing medical assistance to any person who has * * * a cause of action arising out of an occurrence that necessitated the payment of medical assistance, the state agency * * * shall be subrogated, to the extent of the cost of medical care furnished, to any rights the person may have * * * under the cause of action.

The right of subrogation created in this section includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

Minn.Stat. § 256B.37, subd. 1.

The federal anti-lien provision does not explicitly prohibit states from asserting subrogation rights with respect to a medical assistance recipient's cause of action arising out of an occurrence that necessitated the payment of medical assistance. Therefore, the same is true here as with the assignment provision--compliance with both federal and state laws is not impossible per se. But as with the assignment provision, we have to determine whether allowing a subrogation right outside of the state's assigned right to medical expenses would be an obstacle to the purposes of the federal Medicaid scheme. *See* Fla. Lime & Avocado Growers, 373 U.S. at 142-43, 83 S.Ct. 1210; Hines, 312 U.S. at 67, 61 S.Ct. 399 (stating that state law is preempted if it is an obstacle to accomplishment of federal purpose).

[18] Our preemption analysis of the state's subrogation right will be very similar to the analysis of the state's assignment provision because a subrogation right has the same practical effect as an assignment--it puts the state in the shoes of the medical assistance recipient with respect to the recipient's rights against third parties for medical expenses. *See* Hermeling v. Minn. Fire & Cas. Co., 548 N.W.2d 270-273 (Minn.1996) (explaining the distinction between subrogation and indemnity) (overruled on other grounds).

**14 [19] We have already concluded that the anti-lien provision prohibits a state from attempting to recover its medical assistance costs from the property of the recipient through a lien and that the state cannot require an assignment of more than the recipient's right to receive third-party payments *for medical care.* The federal scheme does permit a state to recover medical expenses paid by authorizing an assignment of those rights, but the anti-lien provision effectively prevents the state from recovering the costs of care directly from the recipient. Allowing the state to assert a subrogation right and thus get indirectly what it is

prohibited from attaining directly would defeat the purpose of the federal anti-lien provision in the same manner as the broad assignment of rights discussed above. Pursuing a subrogation right allows an end-run around the protections of the anti-lien provision by using a subrogation right instead of a lien to take part of the recipient's personal property that is protected by the anti-lien provision. Essentially, for purposes of our preemption analysis, an assignment of rights to the state and the state's subrogation right are the same. Therefore, we hold that the state subrogation provision is preempted to the extent that it allows the state to assert a subrogation right against causes of action or settlements for other than medical expenses.

[20] When the state actually obtains the assignment of rights to third-party payments for medical expenses, subrogation is no longer appropriate because the state is now the owner of the medical assistance recipient's claim and no longer needs to be subrogated. *See, e.g.*, *Employers Mut. Cas. Co. v. A.C.C.T., Inc.*, 580 N.W.2d 490, 493 (Minn.1998) (explaining that subrogation does not give a subrogee any independent rights, but merely allows a subrogee to step into the shoes of the *21 subrogor). But subrogation may be appropriate in situations where medical assistance payments have begun before the assignment is made, [FN24] when a medical assistance recipient refuses to make an assignment, or when an assignment is not properly made. In those circumstances, the state will still be able to assert a subrogation right to the extent of medical assistance payments made, but only as to the recipient's right to recover on a claim for medical expenses.

> FN24. Martin's medical assistance application and assignment of rights was not completed until approximately 18 months after medical assistance payments first began.

IV.

The state makes three additional arguments to supplement its main argument that the plain language of Minnesota's lien, assignment, and subrogation statutes does not conflict with federal law or the purposes behind the Medicaid provisions. These arguments are that the state's position is supported by (1) deference to HCFA's interpretation of the federal anti-lien provision, (2) decisions from other jurisdictions, specifically Washington and Utah, and (3) equitable considerations. None of these arguments are persuasive, and we will address each in turn.

A. *Deference to HCFA*

[21][22] The state argues that we must defer to HCFA's interpretation of the federal anti-lien provision. The state asserts that HCFA has decided that the anti-lien provision does not bar a state from imposing a lien on a medical assistance recipient's rights to recover for other than medical care. Deference to agency interpretation is called for, however, only when there is an ambiguity in the expression of congressional intent. *Chevron*, 467 U.S. at 842, 104 S.Ct. 2778 ("If the intent of Congress is clear, that is the end of the matter."); *see also United States v. LaBonte*, 520 U.S. 751, 762 n. 6, 117 S.Ct. 1673, 137 L.Ed.2d 1001 (1997) (concluding no ambiguity, and thus no need to decide whether Sentencing Guidelines Commission is owed deference). We have already concluded that there is no ambiguity in the statement that "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan * * *." 42 U.S.C. § 1396p(a)(1). Similarly, the federal assignment requirement and the third-party recovery provision are not ambiguous and interact smoothly with our interpretation of the anti-lien provision. Because the intent of Congress is clear,

there is no need for deference to an agency interpretation on the grounds that the statute is ambiguous.

**15 [23] Even if we were to conclude that the federal assignment requirement and third-party recovery provision inject some ambiguity into federal law, agency deference is still not appropriate here. When an agency statement does not reflect formal rules or agency adjudications, yet attempts to address an ambiguity in the law, deference to the agency under *Chevron* is not appropriate. *See Christensen v. Harris County*, 529 U.S. 576, 587, 120 S.Ct. 1655, 146 L.Ed.2d 621 (2000) (concluding that opinion letters, policy statements, agency manuals, and enforcement guidelines are not warranted *Chevron*-style deference). Such agency interpretations are only "entitled to respect * * * to the extent that those interpretations have the power to persuade." *Id.* (internal quotation marks omitted); *see also Wis. Dep't of Health and Family Servs. v. Blumer*, 534 U.S. 473, 122 S.Ct. 962, 976 (2002) ("The Secretary [of Health and Human Services'] *22 position [regarding Medicaid law] warrants respectful consideration.").

[24] The state urges us to defer to various agency letters, directives, and approvals demonstrating the agency's interpretation of the anti-lien provision as not prohibiting a state from recovering on third-party actions for other than medical care. These materials include a "Best Practices Guide" that cites Minnesota's subrogation statute as "model legislation" and various letters from HCFA's administrators to state administrators and others stating that medical assistance liens are not prohibited under federal law. These agency materials are not accorded deference because they do not reflect formal rules or adjudications. *Christensen*, 529 U.S. at 587, 120 S.Ct. 1655. And, although these materials are entitled to some respect and may be used to persuade this court, we are not persuaded by the interpretations contained in these materials.

The state has referenced two agency adjudications that, if relevant, would be entitled to deference under a *Chevron* analysis. The two adjudications were made by the Department of Health and Human Services Appeals Board (Board). [FN25] *Cal. Dept of Health Servs.*, DAB No. 1504 (Dep't of Health & Human Servs. Jan. 5, 1995); *Wash. State Dep't of Soc. and Health Services*, DAB No. 1561 (Dep't of Health & Human Servs. Feb. 7, 1996). Both adjudications addressed whether HCFA properly withheld federal funds from a state program based on the state's failure to recover a sufficient amount from settlements between recipients and third-party tortfeasors. In both the California and Washington adjudications, the Board stated that HCFA properly characterized recoveries from third parties first as payments for medical care. The Board reasoned that "[t]his characterization prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care (e.g., by suing for pain and suffering or lost wages rather than for medical costs)." DAB No. 1561, p. 5.

> FN25. If a state disagrees with HCFA's determinations regarding federal financial participation in a state medical assistance program, the dispute is resolved in an adjudication before the Department of Health and Human Services Departmental Appeals Board. 42 C.F.R. § 430.42(b); 45 C.F.R. § § 16.1-.23.

**16 [25] We need not defer to these agency adjudications because they do not address the central issue presented here, which is whether the federal anti-lien provision preempts state laws that purport to allow states to impose liens on recovery of amounts not designated as payment for medical expenses. Indeed, the agency adjudications do not mention the federal anti-lien provision. [FN26]

FN26. As the dissent notes, agency interpretations are only entitled to *Chevron* deference if they are reasonable. *Chevron*, 467 U.S. at 843-44, 104 S.Ct. 2778. In the California adjudication, the Board acknowledges that the statute only refers to an assignment of "payment for medical care." DAB No. 1504; *see also* DAB No. 1561 (relying on DAB No. 1504). However, the Board then concludes that "the statutory scheme as a whole contemplates that the actual recovery might be greater, and, if it is, that Medicaid should be paid first." *Id.* This broad analytical leap is such a significant departure from the plain language of the statute that we conclude it to be unreasonable and not entitled to deference under *Chevron*.

We are nonetheless mindful of the concern expressed in the agency adjudications that Medicaid recipients could fashion a settlement to exclude payment for costs of medical care so as to avoid any obligation to reimburse the state and federal governments. But the state has options other than to ignore a clear provision in federal *23 law that prohibits a lien from being imposed against the property of any individual on account of medical assistance paid. The state can protect its right to reimbursement by participating in the litigation so as to ensure recovery of medical costs paid. In this case, the state did not actively participate in the litigation until settlement, despite being a plaintiff on impleader. But the state did participate at the settlement and did release each defendant from any liability to the state for medical expenses. At this time, the state did establish its claim to part of the settlement proceeds--but in a dispute solely with Martin.

B. *Other Jurisdictions* [FN27]

FN27. The dissent relies upon state supreme court cases from Utah, Washington, and New York, as well as a

single case each from the Second and Eighth Circuits. The state cases are distinguished below and rejected. Additionally, neither federal court of appeals specifically addressed the federal anti-lien provision or considered preemption of state laws. Specifically, the Second Circuit addressed the "general rule that the state may not encumber a Medicaid recipient's property prior to death," but cited only a New York version of the anti-lien statute and relied upon a New York state-created exception. *Sullivan v. County of Suffolk*, 174 F.3d 282, 285 (2nd Cir.1999). Moreover, the Eighth Circuit did not address the issue before this court--the validity of state medical assistance liens and whether such liens were able to be satisfied out of the entire settlement, or only that part attributable to medical expenses. *Doth*, 159 F.3d at 334. Further, as previously noted, *Doth* did not mention the anti-lien provision at all. *Id.*

The state asserts its position is supported by decisions from Washington and Utah. However, in reaching their respective holdings, neither Washington nor Utah addressed the issue of preemption. In *Wilson v. State*, the Washington Supreme Court concluded that the federal anti-lien provision was irrelevant because the state placed a lien on the recovery itself, and therefore not on the "property" of the recipient. 142 Wash.2d 40, 10 P.3d 1061, 1065-66 (2000). Similarly, in two companion cases, the Utah Supreme Court concluded that the anti-lien provision was not implicated when a state lien was placed on a settlement recovery. *S.S. v. State*, 972 P.2d 439, 442 (Utah 1998); *Wallace v. Estate of Jackson*, 972 P.2d 446, 448 (Utah 1998). The Utah court concluded that "payments made by a third party do not legally become the property of the recipient until after a valid settlement which must include reimbursement to the State for Medicaid benefits." *Wallace*, 972 P.2d at 448 (citing *S.S.*, 972 P.2d at 442). Washington relied on Utah, which in turn relied on the New York case, *Cricchio v. Pennisi*, which also concluded that

the lien on settlement proceeds attaches to the property of a third party. 90 N.Y.2d 296, 660 N.Y.S.2d 679, 683 N.E.2d 301, 306 1997).

The New York court, and later the Washington and Utah courts, reached the conclusion that settlement proceeds were not the property of the medical assistance recipient. But when they reached this conclusion, they failed to unbundle the sticks that make up a personal injury action. These courts correctly recognize that the federally-required assignment of rights to third-party medical expense recoveries gives a state the right, up to the amount of the state's expenditures, to any recovery or settlement for that right to recover. To the extent that a settlement is for medical expenses, those proceeds are the property of the state by virtue of the required assignment. But these courts failed to recognize that a personal injury tort action against potentially liable third parties comprises more than a right to recover for medical expenses. The tort action includes claims for pain and suffering, ***24** emotional distress, loss of earnings, and other familiar tort claims. The part of any settlement attributable to these unassigned claims is the property of the medical assistance recipient during his life, and the state has no right to these claims under the assignment. So while the other states' courts are correct in their conclusions that a recovery for medical expenses is not the property of a medical assistance recipient, they ignore the part of the recovery or settlement for claims other than medical expenses. We are therefore unpersuaded by the analysis of the Washington and Utah courts on this issue.

****17** Additionally, the cases from New York, Utah, and Washington cannot be relied upon because of other problems in their analysis. In *Cricchio*, the New York court apparently concluded that New York's statutory analogue to the federal anti-lien provision was not violated by the imposition of a state lien because the state statute created an

exception for the lien, yet the court did not explain how this state-created exception could trump the federal anti-lien provision. *Cricchio*, 660 N.Y.S.2d 679, 683 N.E.2d at 304. But the state exception was not the basis for the court's holding; rather, the court relied upon the conclusion that the anti-lien provision was not violated because the lien attaches to the settlement proceeds which the court deemed to be the property of the third party. *Id.*, 660 N.Y.S.2d 679, 683 N.E.2d at 305.

The dissent and the aforementioned cases implicitly acknowledge that whether the cause of action or settlement proceeds are the property of the recipient determines the applicability and relevance of the anti-lien provision. Each determines that the federal anti-lien provision is irrelevant by concluding that the settlement proceeds are no longer the property of the recipient. But, by doing so, they fail to grapple with the key issue that underlies our analysis. This key issue, in fact, is the property issue. Specifically, both the dissent and the cases cited gloss over why these causes of action are no longer the property of the medical assistance recipient. On the other hand, our analysis recognizes the limited nature of the required assignment. Therefore, after a full analysis, we conclude that the causes of action and claims for other than medical expenses--and settlement proceeds therefrom--are the property of the recipient and therefore the federal anti-lien provision is relevant.

C. *Equitable Considerations*

[26] We are also mindful of the state's equitable argument that it needs to preserve and recover Medicaid assets. But our resolution of the issue before us does not eliminate the state's ability to recover medical expenses when third parties are liable. Rather, our conclusion leaves the federal scheme intact and the state retains the assignment of a medical assistance recipient's right to recover for medical expenses

against potentially liable third parties. Indisputably, the state's rights are limited--they only extend to a recipient's right to recover for medical expenses. The state has no interest under the assignment in any of the recipient's recoveries from third parties for claims other than for medical expenses. But the state does not have to wait for the recipient to initiate an action. Under harmonized federal and state law, medical assistance recipients are required to assign to the state their rights to receive payment for medical expenses from any potentially liable third parties. This assignment enables the state to acquire the recipient's property rights to this particular claim and to take independent legal action, or, as in this case, to be joined as a party to the recipient's action. Thus, the state can take an active role as a ***25** plaintiff in its own right and does not have to rely on the efforts of others to ensure a recovery of medical assistance expenses. [FN28] Therefore, even though the method of obtaining medical assistance reimbursement that the state seeks in this litigation is not available to it, the state has other alternatives available to recover medical expenses. [FN29]

FN28. It is important to remember that this case is not about the amount of recovery, but rather the method of recovery. Contrary to the implication of the dissent that our holding drastically curtails the state's ability to recover, the state's active participation in recovery efforts may in some cases actually increase its ultimate recovery. Under Minn.Stat. § 256B.042, subd. 5, the state is limited to a two-thirds recovery under the medical assistance lien, even if the only claim is for recovery of medical expenses. Under our holding, the state has no such limitation on the amount of its recovery. Rather, the state is entitled to recover the full amount of the assigned claim for medical expenses due from potentially liable third parties.

FN29. Contrary to the dissent's assertion, the state will not be "shackled" from recovering its medical assistance expenditures unless the recipient designates a part of a settlement for medical expenses. The state will not be forced to rely on the recipient's "labeling" of settlement amounts. Rather, as noted above, the state has its own independently owned claim for medical expenses against potentially liable third parties. With such a claim, the state must take appropriate steps with respect to its assigned claim for medical expenses, whether that is initiating a lawsuit, participating in a lawsuit initiated by the recipient, or taking part in settlement negotiations. Here, the state is only entitled to a part of the settlement proceeds because it released the third parties from further liability, relying solely on its lien and subrogation rights.

**18 The state uses Minnesota's guaranteed one-third recovery scheme to support its position. But the same rationale that would allow a medical assistance recipient to receive a guaranteed one-third recovery also would allow the state to take away that guarantee and leave the recipient with nothing until the state had been paid back in full. Thus, by emphasizing the reasonableness of its position, the state fails to acknowledge the logical consequences of its argument.

We also note that the dissent fails to consider that as a logical consequence of its reasoning, Minnesota's participation in the Medicaid program may be jeopardized. The current mechanism in section 256B.042, subd. 5, allowing a one-third guaranteed recovery to a plaintiff/recipient is much the same as the systems in California and Washington that were criticized by the Department of Health and Human Services' Departmental Appeals Board (Board) because specified percentages or amounts of third-party recoveries were given back to

recipients. *See* Part IV, A, *supra*. Under a pure application of the Board's analysis as adopted by the dissent, Minnesota would be unable to guarantee any recovery to the recipient, because the Medicaid expenses must first be taken from any recovery, regardless of its "label." Thus, even under the dissent's analysis, Minnesota's third-party recovery system is in jeopardy.

Our decision also does justice to Hoff and other medical assistance recipients. The state has paid for Hoff's medical expenses and should be entitled to reimbursement when a third party is liable for those expenses. But, in the words of now Chief Justice Gerry L. Alexander of the Washington Supreme Court, "the fund should be replenished only from amounts that a Medicaid recipient receives as reimbursement for elements of damage for which the State has assumed responsibility." *Wilson*, 10 P.3d at 1070 (Alexander, J., dissenting). Here, the state attempts to recover for medical expenses from a settlement for a cause of action that included ***26** pain and suffering, loss of earnings, loss of earning potential, and disfigurement--none of which is compensated by the state through medical assistance. These claims belong to Hoff alone, and may provide some relief or an increase in quality of life that is not possible through medical care.

V.

[27] We must now apply these holdings to the specific facts of this case. At the time of the accident, Hoff acquired a "bundle of sticks," which represented all of his potential rights to recover against those responsible for his injuries. As a condition of receiving medical assistance from the state, Martin, on Hoff's behalf, assigned to the state one stick from that bundle--Hoff's specific right to recover medical expenses from those responsible for Hoff's injuries. [FN30] At that point, the state became the sole owner of Hoff's right to recover against any third parties for medical expenses. But

Hoff retained ownership of the remaining sticks in the bundle-- that is to say, his right to recover for pain and suffering, emotional distress, disability, disfigurement, loss of earnings, and loss of earning capacity. To the extent that Martin's settlement with the defendants was for this larger bundle of sticks (the original tort action minus the right to recover for medical care), the proceeds are Hoff's personal property, and as such are protected by the federal anti-lien provision. [FN31]

FN30. The assignment in Martin's medical assistance application reads as follows:
As a condition of eligibility for medical assistance, I assign to the State of Minnesota any rights available to me under automobile or private health care coverage and any rights to payment for medical care from any third party for myself or my dependents. I agree to cooperate with the State in any legal action brought against a third party for payment of medical expenses or subsistence.

FN31. In the workers' compensation area, we have long recognized a compensation recipient's ability to settle third-party claims for bodily injury and exclude from those settlements claims or damages not recoverable under workers' compensation, so long as there is notice to the employer or carrier. *See, e.g.*, *Naig v. Bloomington Sanitation*, 258 N.W.2d 891, 894 (Minn.1977); *Lang v. William Bros. Boiler & Mfg. Co.*, 250 Minn. 521, 531, 85 N.W.2d 412, 419 (1957);. As we see no relevant distinction for our analysis, we also recognize the divisibility of a medical assistance recipient's claims against a third party into claims for medical expenses (assigned to the state) and claims for other damages (owned by the recipient).

**19 It is unclear from the record what claims or rights to recover were part of the settlements. Martin, in her memoranda of law to the district court and in her briefing on appeal, erroneously characterizes the nature of the settlements as only for Hoff's claims and not for the state's claim pleaded by Martin for the state as plaintiff on impleader (i.e., the state's assigned claim for medical expenses). The settlement agreement with the city specifically incorporated the amended complaint by reference and purported to encompass all claims stated in the amended complaint, which included Hoff's claim for medical expenses and the separately pleaded claim for medical expenses paid by the state. The settlement agreements with the township and Tlougan's estate were not as comprehensive as the agreement with the city and did not contain similar language that clearly encompassed all claims in the amended complaint. This omission calls into question whether the state's claim pleaded by Martin was included in the settlement with the township and Tlougan's estate. But these settlement agreements do contain sufficient language indicating that the settlement was *27 in satisfaction of the state's claims, although this language is not as straightforward as that in the settlement agreement with the city. Therefore, based upon our reading of the record below, we conclude that the settlements with defendants included and released all claims in the amended complaint, including the state's claim for medical expenses.

[28] The state initially received an assignment of Hoff's rights to recover for medical expenses against any potentially liable third parties, including defendants, but as part of the settlements the state released defendants from all further liability. Because of the assignment made in the medical assistance application and by virtue of the state's claim pleaded by Martin on impleader, the state's assigned claim for medical expenses was necessarily a part of the settlements. The result of the settlements and the releases is

that the state's recovery of expenses from the defendants for Hoff's medical care is now limited to the settlement proceeds. Therefore, the state is entitled to that part of the settlements that represents a recovery on its claim for medical expenses.

We are not able to determine from the record what part of the settlement proceeds is attributable to Hoff's nonassigned personal injury claims and what part is attributable to the state's separately owned right to recover medical expenses. In fact, it appears that the district court did not make such a determination. Accordingly, the district court's grant of Martin's motion to dismiss the state's claim to any of the settlement proceeds was in error. The court's conclusion that the settlement proceeds were Hoff's sole and exclusive property is not supported by the record, and therefore we must remand to the district court for further proceedings and clarification on the distribution of the settlement proceeds between Hoff's claims and the state's claim. Ultimately, that part of the settlement proceeds attributable to payment for medical expenses belongs to the state under the assignment; the remainder of the proceeds belongs to Hoff.

**20 On remand, the district court must specifically consider that the state's claim was part of the settlements and must specifically allocate the settlement proceeds among Hoff's nonassigned personal injury claims (excluding any recovery for medical care or expenses) and the state's separately owned claim for medical expenses. Here, it is important to remember that this case involves a settlement, and as with all settlements, represents a compromise of the parties' claims and damages. Had this case gone to trial, a jury would have been required to allocate the damages among the component claims. This court-approved settlement is no different and should be similarly allocated by the court in recognition of the nature of the settlement as a compromise. Once the court has made that allocation, that part of the settlement proceeds

which represents payment for Hoff's medical expenses paid by the state must be awarded to the state; all other settlement proceeds belong to Hoff.

Reversed and remanded.

RUSSELL A. ANDERSON, Justice (dissenting).

I respectfully dissent. At the time Martin settled the personal injury cause of action against multiple defendants on behalf of her disabled son, the state, at her request, had expended over $600,000 towards his medical treatment. The medical treatment and the payments of public money for that treatment continued. Yet the effect of the majority's holding is that the state should not be able to recover on its lien for reimbursement of even a portion of the public money expended for *28 medical treatment. Given the state's significant expenditure on Hoff's behalf, the settlement funds at issue here belong to and should be returned to the public to the extent necessary to partially reimburse Medicaid.

The majority's holding is contrary to the purposes of the federal Medicaid law. The majority purports to construe the federal statute as a whole and interpret the federal anti-lien provision in light of the surrounding sections, but ultimately fails to adequately address the federal requirement that states recoup their expenditures out of proceeds from liable third parties. In addition, despite the contrary results reached in every other court that has considered the question presented in this case, the majority fails to acknowledge even an ambiguity that would allow it to defer to the federal agency charged with day-to-day administration of this complex statute. Focusing on the anti-lien provision, the court allows parties to subvert the principle that Medicaid should be the payor of last resort and jeopardizes the state's recovery of any of the significant funds extended for

payment of medical expenses on behalf of Medicaid beneficiaries.

Although the federal anti-lien provision is broad, we must read related statutes *in pari materia*, keeping in mind the purposes of the entire federal scheme and the strong presumption against preemption of state law. *See* Erlenbaugh *v. United States*, 409 U.S. 239, 243-44, 93 S.Ct. 477, 34 L.Ed.2d 446 (1972); *Forster v. R.J. Reynolds Tobacco Co.*, 437 N.W.2d 655, 658 (Minn. 1989). In my view, the majority has lost sight of these important principles. Although appellant had a property right in her cause of action against the third party, she disposed of this property right to the extent of medical expenses paid when in her application for ~~medical~~ assistance benefits she agreed to apply *all* proceeds from a liable third party and when she assigned to the state *any* rights to third-party payments. *See* Minn.Stat. § 256B.056, subd. 6 (2000). The right to dispose of property has long been considered an inherent aspect of property ownership, *see* Congdon *v. Congdon*, 160 Minn. 343, 363, 200 N.W. 76, 83 (1924), and nothing in the federal or state Medicaid law, including the anti-lien provision, suggests the right to dispose of a cause of action through assignment to the state is impaired.

**21 Once that broad assignment was made, the anti-lien provision was no longer operative because the recipient's causes of action (to the extent of the state's expenditures) were no longer his property, [FN1] and the conflict between state and federal law the majority finds is irrelevant. By looking first and foremost at the anti-lien provision instead of construing all provisions together, the majority overlooks a construction of the statute that avoids preemption problems.

FN 1. The majority claims this analysis "misses the point." However, it is the same analysis that the majority applies. That is, I agree with the majority that the

> medical assistance recipient has assigned *something*, on which the anti-lien provision does not operate because once assigned the cause of action is no longer the property of the recipient. I differ with the majority with respect to the *scope* of what has been assigned, not with respect to whether the assignment reflects a right or an obligation.

This construction is consistent with the third-party recovery provisions requiring states to recover the full amounts of their expenditures under Medicaid. The federal statutes prohibit a lien on the recipient's property during the recipient's lifetime, but at the same time require the recipient to give the state, *"to the extent that payment has been made under the State plan* * * * the rights of such individual to payment ***29** by any other party for such health care items or services." 42 U.S.C. § 1396a(a)(25)(H) (Supp. V 1999) (emphasis added). Under federal law, "the State is considered to have acquired the rights of such individual to payment by any other party for * * * health care items or services * * *." *Id.* The federal mandatory assignment provision requires states to enact laws that require recipients to assign "any rights * * * to support * * * and to payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1994).

The majority construes the third-party recovery provision as limited to the recipient's right to recover payment for medical expenses. However, the statute requires a state to have in place laws:

> that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have

acquired the rights of such individual to payment by any other party for such health care items or services.

42 U.S.C. § 1396a(a)(25)(H). A fair reading of the statute indicates that "such health care items or services" in the last clause refers to what the state has paid for, not what the recipient might recover through a settlement. Congress' intent is to limit the recovery only "to the extent that payment has been made under the State plan," not to amounts out of a third-party settlement that the recipient agrees to label payment for medical expenses.

Accordingly, the state's assignment provision requires that the recipient apply or agree to apply "*all proceeds* received or receivable" from any third party liable for the costs of the medical care, and that the applicant assign to the state "any rights to medical support *and* third party payments." Minn.Stat. § 256B.056, subd. 6 (2000) (emphasis added). This statute conforms with federal statutory requirements that state laws require a recipient to assign rights to the state for medical payment and that the laws give states the right to those payments to the extent that payment has been made under the state plan. 42 U.S.C. § § 1396a(a)(25)(H) and 1396k(a). With respect to the state assignment provision, the state law does not conflict with federal law, but advances the purposes and objectives of the federal law.

**22 Other state courts attempting to harmonize the federal anti-lien provision and the state's right to recover from third parties have applied this reasoning. In *Wallace v. Estate of Jackson*, 972 P.2d 446 (Utah 1998), *cert. denied*, *McNeil v. Utah, Medicaid Section*, 528 U.S. 810, 120 S.Ct. 42, 145 L.Ed.2d 38 (1999), the Utah Supreme Court held that payments made by a third party do not legally become the property of the recipient until after settlement "'because third party settlement proceeds have been specified by the recipient as belonging to the State Medicaid Agency as a precondition of the recipient's eligibility.'" *Id.* at 448 (quoting state's brief).

The Utah court noted that the anti-lien provision has coexisted for many years with the requirement that states seek reimbursement from third parties who are legally liable for the medical payments, and noted that harmony between these provisions can be achieved if the assigned rights are not considered part of the recipient's property. *Id.*

Likewise, in *Wilson v. State*, 142 Wash.2d 40, 10 P.3d 1061, 1064-65 (2000), the Washington Supreme Court held that all settlement proceeds belong to the state because they were assigned as such. The ***30** court stated, "due to the lien being placed on the settlement prior to it becoming the property of the Medicaid recipient, the [anti-lien provision] is irrelevant." *Wilson*, 10 P.3d at 1065 n. 2; *see also Cricchio v. Pennisi*, 90 N.Y.2d 296, 660 N.Y.S.2d 679, 683 N.E.2d 301, 305 (1997) (reasoning that because the recipient has assigned rights to the state to recover medical expenses from a third party, and the state is subrogated to the recipient's rights, the settlement proceeds are the property of the third party which are owed to the state). Thus, the Washington and Utah supreme courts treat all third-party settlement proceeds in the same fashion that the majority treats only third-party payments for medical expenses. Presented with the identical issue as is presented here, the Washington court concluded that, "the state is not limited to recovery from only that portion of the settlement specifically allocated to medical expenses. The federal statute states recovery is to the extent of payment made by the state for health care items or services." 10 P.3d at 1066. [FN2]

> FN2. The majority accuses the highest courts of two sister states of failing "to grapple with the key issue" by concluding that the settlement proceeds are no longer the property of the recipient. Again, this is the same *method* by which the majority gives effect to the assignment provision, however. Like the Utah and Washington high courts, the majority also considers the

assigned causes of action to not be the property of the recipient, but simply concludes that the assignment is more limited (to medical expenses) than the assignment as interpreted by the Utah and Washington supreme courts.

Likewise, federal courts have not considered the federal anti-lien provision to bar states from pursuing settlement proceeds to satisfy a lien based on the state assignment and subrogation rights. *Sullivan v. County of Suffolk*, 174 F.3d 282, 286 (2d Cir.1999) (holding that, based on the assignment and subrogation scheme, the state may first satisfy its lien before the settlement proceeds are placed in a supplemental needs trust for the recipient); *Norwest Bank of N.D., N.A. v. Doth*, 159 F.3d 328, 333-34 (8th Cir.1998) (holding that the state may satisfy its lien from settlement proceeds before funds are placed in a special needs trust but declining to rule on the effect of the anti-lien provision). [FN3] At a minimum, what the majority finds to be patently clear has eluded the Second and Eighth Circuits and the highest courts of three states, every court that has considered the issue.

FN3. The majority claims that *Doth* is here taken out of its context, which involves the placement of an entire recovery from third party tortfeasors in a special or supplemental needs trust (SNT) so as to avoid the state's lien. The distinction the majority makes between shielding an entire recovery (not allowed) and shielding only part of a recovery (apparently allowable) eludes me. However, other than using the vehicle of a SNT, shielding the entire recovery is exactly what Martin seeks to do here. She claims she is entitled to the full $220,000 from the third party tortfeasor.
While the majority and I both acknowledge that *Doth* did not deal expressly with the anti-lien statute, the court in *Doth* did expressly reject a construction of the SNT statute that would "eviscerate Congress's clearly

expressed intention that these funds be repaid and negate the Social Security Act's comprehensive scheme permitting states to place these liens." 159 F.3d at 333 (internal quotation marks omitted).

**23 Instead the majority here attempts to harmonize the federal statutes by limiting the effect of the assignment provision to payments for medical expenses. This construction frustrates the purpose of the Medicaid program, however. As the Eighth Circuit held, allowing Medicaid recipients to avoid reimbursing the state for amounts paid on the recipient's behalf would "eviscerate Congress's clearly expressed intention that these funds be repaid and negate the Social Security Act's *31 comprehensive scheme permitting states to place these liens." *Doth*, 159 F.3d at 333 (internal quotation marks omitted). Thus; while the anti-lien provision is broadly written, equally clear from the entire context of federal Medicaid law is the principle that the state must be able to recoup what it has spent on medical care for Medicaid recipients.

Congress' apparent intent is to replenish and preserve Medicaid funds, providing support only when no other resources are available. Consolidated Omnibus Budget Reconciliation Act, H.R. Conf. Rep. No. 99-453, at 542 (1985); *Wilson*, 10 P.3d at 1064. Federal statutes accomplish this policy by requiring that a recipient assign rights of recovery to the extent of a third party's liability and that states retain the amount collected under the assignment to first reimburse Medicaid. 42 U.S.C. § 1396k (1994). To allow recipients to shield from recovery by the state amounts labeled "pain and suffering" or other elements of damage conflicts with the clear congressional intent that Medicaid be the payor of last resort, and that the state be able to recoup its expenditures from funds to which the beneficiary was entitled before the assignment. [FN4]

FN4. The majority claims that this analysis fails to consider the objective of protecting a medical assistance recipient's property during his lifetime. As explained herein, the anti-lien provision operates to give effect to this purpose for nonassigned property.

The majority's willingness to parse out the "sticks" of Hoff's settlement is also inconsistent with our previous treatment of tort settlements as they relate to eligibility for Medicaid. In *In re Welfare of K.S.*, 427 N.W.2d 653 (Minn. 1988), we addressed whether a tort settlement was an available asset for purposes of determining eligibility for medical assistance. In that case an amicus curiae advocated a construction of the term "available assets" that would allow only that portion of a tort settlement intended to compensate the beneficiary for future medical expenses to be considered available, leaving compensation for pain and suffering or other claims not available. *Id.* at 659. We noted that the state's subrogation right extends to "all portions of the cause of action, 'notwithstanding any settlement * * * or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.'" *Id.* (quoting Minn.Stat. § 256.37, subd. 1). In *K.S.*, we found this statute demonstrated a clear legislative intent that the purpose for which a settlement was received, whether for medical expenses or pain and suffering, did not determine the availability of those funds for purposes of eligibility for medical assistance. 427 N.W.2d at 659. Today the majority makes the directly opposite conclusion, by holding that settlement funds must be parsed out according to purpose and the state's right to recover its expenses is limited to those labeled as for medical costs.

**24 Despite the fact that the highest courts of two states reached the opposite conclusion than that reached by the majority, and despite the purposes of the Medicaid law to allow the states to recover their expenditures, and despite our previous rejection of parsing out portions of a settlement

fund depending on the purpose for which it was received, the majority refuses to acknowledge even an ambiguity with respect to the anti-lien provision and the third-party recovery provisions. These provisions create at least an ambiguity with respect to the reach of the anti-lien provision, which should compel us to acknowledge the rulings of the federal agency charged with administering this complex statute. *See* *32 *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843-44, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984) (holding that if a court finds ambiguity in the federal statute, it must defer to the administrating agency's interpretation if that interpretation is reasonable.)

The two adjudications [FN5] referenced by the majority are entitled to deference, as they reflect the agency's interpretation of the scope of the assignment and lien provisions. In the California decision, the Board upheld HCFA's interpretation of Medicaid statutes as requiring full Medicaid reimbursement before the recipient may collect any third-party settlement proceeds. *Cal. Dep't of Health Servs.*, DAB No. 1504 (Dept of Health & Human Servs. Jan. 5, 1995). HCFA thereby disapproved of California's practice of allowing recipients to retain portions of third-party settlements that did not represent payment for medical care. The Board stated:

> FN5. I agree with the majority that agency letters, directives and approvals are not entitled to full deference because they do not reflect formal rules or adjudications. However; as the United States Supreme Court has recently made clear, *Chevron* did not eliminate a court's ability to give some lesser form of deference to agency interpretations appearing in other forms, "given the 'specialized experience and broader investigations and information' available to the agency." *United States v. Mead Corp.*, 533 U.S. 218, 121 S.Ct. 2164, 2167, 150 L.Ed.2d 292 (2001) (quoting *Skidmore v. Swift & Co.*, 323

U.S. 134, 139, 65 S.Ct. 161, 89, L.Ed. 124 (1944)). The agency pronouncement may be due a "respect proportional to its 'power to persuade'." *Mead*, 533 U.S. at 220, 121 S.Ct. at 2167 (quoting *Skidmore*, 323 U.S. at 140, 65 S.Ct. 161).

Of the various materials respondent directs us to, one memorandum from HCFA adequately describes the agency's interpretation of the anti-lien provision and is entitled to this lesser form of deference. A 1994 memorandum from the HCFA regional administrator to state Medicaid directors stated that liens are valid against a tortfeasor's property or against funds set aside to settle litigation that are not the recipient's property. Health Care Financing Administration Regional Identical Letter No. 94-134 (Sept. 1994). The memo acknowledges the anti-lien provision and interprets it not to apply to recoveries from third-party tortfeasors because such funds are not the recipient's property. This agency interpretation is consistent with the rulings in *Wallace* and *Wilson*, and while not accorded full *Chevron* deference, we should consider it to have some persuasive force.

HCFA's position is directly supported by these provisions of the Act. Recipients, as a condition of eligibility, must assign their rights to payment for medical care. States are then charged with the responsibility of seeking third party recovery pursuant to such assignments. States are further required to seek as much reimbursement as possible, i.e., to the extent of the third party's liability. Finally, when a recovery is made, the Act sets forth a distribution scheme which requires the Medicaid program to be reimbursed prior to distributing any funds to the recipient. While section 1912(a) refers to assignment only of "payment for medical care," the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first.

The Washington adjudication involved a state law that allowed the state to reduce the amount of its lien if the settlement amount was not sufficient to pay all medical expenses and other types of damages. *Wash. State Dep't of Soc. & Health Servs.*, DAB No. 1561 (Dept of Health & Human Servs. Feb. 7, 1996). HCFA maintained that, under the mandatory assignment provision, Medicaid must be reimbursed in full before the recipient receives any settlement proceeds. The Board concluded that HCFA reasonably characterized third-party recovery proceeds first as payments for medical care, stating, "[i]n cases where a third party has caused the need for medical *33 care and is liable for its payment, the Act looks to that third party to reimburse the public." DAB No. 1561, p. 5. The Board found that "[t]his characterization prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care (e.g., by suing for pain and suffering or lost wages rather than for medical costs)." *Id.* [FN6]

> FN6. Rather than adopt in their entirety these board adjudications as the majority claims, I cite these adjudications only for the agency's construction of the federal third-party recovery provision supporting its conclusion that the public should be repaid before a medicaid recipient enjoys the fruits of a settlement with a third-party tortfeasor. Whether the agency would view Minnesota's one-third recovery provision in section 256B.042, subdivision 5 as depriving the federal Medicaid program of reimbursement dollars was not before the agency and is not now before the court.

**25 We may not impose our own construction of the statute and are bound by the agency's interpretations established in adjudications if they are reasonable. *Chevron*, 467 U.S. at 843-

44, 104 S.Ct. 2778. The agency's interpretations recognize the conflict between seeking reimbursement to the full extent of a third party's liability and the potentially limiting language of collecting "payments for medical care," just as conflict appears at first glance between the third-party recovery statutes and the anti-lien provision. Relying on the overall scheme of the Medicaid statutes and the policy that Medicaid is to be the payor of last resort, the agency resolves any perceived conflict by interpreting the statutes to require that recipients assign to the state rights to *any* payments from a liable third party for purposes of reimbursing Medicaid. Because appellant thereby disposed of any property right she had in a third-party recovery (to the extent of medical expenses paid), the anti-lien provision was not operative.

The majority dismisses the agency adjudications as not addressing the anti-lien provision. However, in each case the state argued that the assignment provision was limited to payment for medical care, and that HCFA could not be reimbursed out of funds designated for other purposes, just as the majority holds. The agency soundly rejected that position in light of the very real possibility of manipulation of tort awards by recipients who seek to prevent the public from being reimbursed. Manipulation is exactly what the majority allows. Under the majority's interpretation of this statute, appellant would be able to characterize the entire $220,000 as payment for pain and suffering, despite the significant damages in the form of medical expenses that have been incurred on Hoff's behalf. As the agency explained:

> Contrary to what California argued, it is not unfair completely or substantially to deny Medicaid recipients access to their settlements. If Medicaid had not paid their medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlements. As Medicaid recipients, they do not have such debts because

> the public has paid their medical expenses. Therefore, in cases where Medicaid has incurred the "debt" for recipients, it is not unfair for HCFA to require complete reimbursement from these liability funds.

DAB No. 1504, p. 8. In this case, appellant does not have over $600,000 in debt for medical expenses because the state Medicaid program has paid for Hoff's medical care. Yet under the majority's theory the state is shackled from recovering any of its expenditures unless appellant designates payments out of a settlement as for medical expenses instead of pain and suffering ***34** or other elements of damages. Thus, the majority allows appellant's labeling of her items of damages to control whether the government can recoup its expenditures. In this case, the state will continue to pay for Troy Hoff's medical expenses while appellant has at her disposal not insignificant funds from liable third-party tortfeasors that might be used to satisfy that obligation. That result seems to me both absurd and contrary to congressional intent.

****26** As the agency adjudications illustrate, the federal government is quick to penalize states for failure to recoup the amounts the federal government has expended on behalf of Medicaid recipients. The majority's ruling jeopardizes Minnesota's participation in the Medicaid program by making it nearly impossible for the state to recover from third parties responsible for injuries and disabilities of Medicaid recipients. At a minimum, the ruling will require the state to pursue third-party tortfeasors independently, notwithstanding the fact that the legislature has specifically allowed the attorney general to initiate and prosecute an independent action only if "no action has been brought" by the recipient. Minn.Stat. § § 256.015, subd. 3, 256B.042, subd. 3 (2000). To that extent, the majority ruling is further contrary to legislative intent. Moreover, while the state can pursue third-party tortfeasors directly, nothing would prevent the recipient from intervening in that lawsuit and

labeling a settlement pain and suffering so as to thwart the government's recovery. Again, that cannot be what congress or the legislature intended.

I would hold, consistent with the decisions of other courts interpreting the federal Medicaid laws, that the federal Medicaid law does not preempt state law in cases where the state seeks reimbursement for a Medicaid recipient's medical costs by placing a lien against third-party settlement proceeds.

STRINGER, Justice (dissenting).

I join in the dissent of Justice Russell A. Anderson.

LANCASTER, Justice (dissenting).

I join in the dissent of Justice Russell A. Anderson.

642 N.W.2d 1, 2002 WL 433356 (Minn.)

615 N.W.2d 867
(Cite as: 615 N.W.2d 867)

Court of Appeals of Minnesota.

Joan MARTIN, guardian ad litem for Troy HOFF,
Respondent,
and
State of Minnesota, plaintiff on impleader, Appellant,
v.
CITY OF ROCHESTER, et al., Defendants.

No. C3-00-398.

Aug. 15, 2000.
Review Granted Oct. 17, 2000.

Motorist who suffered brain damage in motor vehicle accident, and on whose behalf medical assistance payments were made, brought personal injury action to recover for underlying injuries, and State filed lien seeking reimbursement of medical expenses it had paid. The District Court, Olmsted County, James L. Mork, J., held that statute allowing lien conflicted with federal law, and was invalid. State appealed. The Court of Appeals, Davies, J., held that statute granting State lien for cost of medical care covered through medical assistance program against any and all causes of action on part of recipient does not conflict with, and thus is not preempted by, federal Medicaid statute.

Reversed.

West Headnotes

[1] States 18.5
360k18.5 Most Cited Cases

Under preemption doctrine, which stems from supremacy clause of Federal Constitution, conflicts between federal and state law are to be resolved in favor of federal law. U.S.C.A. Const. Art. 6, cl. 2.

[2] States 18.5
360k18.5 Most Cited Cases

[2] States 18.11
360k18.11 Most Cited Cases

Three-part analysis used to determine whether a federal statute preempts operation of a state statute, pursuant to supremacy clause, looks at whether (1) compliance with both the federal and state provisions is impossible, (2) preemption is express and unequivocal in the language of the federal statute, and (3) congressional preemptive intent is implicit in the overall scheme of federal and state regulation. U.S.C.A. Const. Art. 6, cl. 2.

[3] Social Security and Public Welfare 241.60
356Ak241.60 Most Cited Cases

[3] Social Security and Public Welfare 241.70
356Ak241.70 Most Cited Cases

[3] States 18.79
360k18.79 Most Cited Cases

State statute under which State is ~~granted lien~~ for cost of medical care covered through medical assistance program against any and all causes of action on part of assistance recipient does not conflict with, and thus is not preempted by, federal Medicaid statute under which no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid under State plan; lien created by State statute is simply a device to

protect State's legitimate subrogation interest, and does not allow State to make claim on property not connected to assistance provided, or prevent all recovery by assistance recipient. Social Security Act, § 1917(a)(1), as amended, 42 U.S.C.A. § 1396p(a)(1); M.S.A. § 256.015, subd. 1.

[4] Social Security and Public Welfare 241
356Ak241 Most Cited Cases

State may impose a lien on a personal injury tort claim to secure reimbursement of medical assistance benefits it has paid for injuries underlying tort claim. M.S.A. § 256.015, subd. 1.

[5] Appeal and Error 767(1)
30k767(1) Most Cited Cases

Testimony of deputy administrator of federal agency before Senate Subcommittee, pamphlet regarding "Third Party Liability in the Medicaid Program," and State Medicaid Manual, which contained only general information regarding medical assistance program, and were matters of public record that reviewing court could have researched on its own if so inclined, were properly included in appendix to appellate brief in matter involving validity of State's lien against personal injury tort claim asserted by recipient of medical assistance benefits.

[6] Appeal and Error 714(5)
30k714(5) Most Cited Cases

Party may submit report to appellate court as part of its brief where report is a matter of public record, and court could refer to such a report in the course of its research if so inclined.

***868** Syllabus by the Court

The state may impose a lien on a personal-injury tort claim to secure reimbursement of medical-assistance benefits it had paid because of the injuries underlying the tort claim.

Charles A. Bird, Bird & Jacobsen, Rochester (for respondent Martin).

Mike Hatch, Attorney General, Suzette C. Schommer, Assistant Attorney General, St. Paul (for appellant).

Michael A. Bryant, Bradshaw & Bryant Law Offices, Waite Park (for amicus curiae Minnesota Trial Lawyers Association).

Considered and decided by HALBROOKS, Presiding Judge, DAVIES, Judge, and PETERSON, Judge.

OPINION

DAVIES, Judge

The state claims that the district court erred in finding that Minnesota's medical-assistance lien provision is in conflict with federal Medicaid law. Because we find that compliance with both state and federal law is possible, we reverse.

FACTS

Troy Hoff suffered brain damage in a motor-vehicle accident and was permanently disabled. Respondent Joan Martin, Hoff's mother, applied for and received medical assistance on Hoff's behalf and, under Minnesota statutes, assigned Hoff's rights to any insurance recovery to appellant State of Minnesota.

Respondent then brought a personal-injury action against the City of Rochester and others on behalf of her son. Under

Minn.Stat. § 256.015, the state filed a lien against this action to secure reimbursement of medical expenses it had paid to treat his injuries. The district court held that Minn.Stat. § 256.015 was invalid because it conflicted with 42 U.S.C. § § 1396k and 1396p, and, thus, the federal statute preempted the state statute. On appeal, the state contends there is no preemption and the federal statute does not bar the state from placing a lien on the tort recovery.

ISSUES

I. Does federal law allow the state to impose a lien on a third-party tort settlement to secure reimbursement of medical assistance paid?

II. Is this court required to strike appellant's appendix as outside the record?

ANALYSIS

I.

[1] The preemption doctrine stems from the Supremacy Clause of the United States Constitution, which provides that the laws of the United States "shall be the supreme Law of the Land * * * any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2. According to the preemption doctrine, conflicts between federal and state law are to be resolved in favor of federal law. *Fidelity Fed. Sav. and Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 152-53, 102 S.Ct. 3014, 3022, 73 L.Ed.2d 664 (1982).

[2] Minnesota's three-part analysis to determine whether a federal statute preempts operation of a state statute looks at whether: (1) compliance with both the federal and state provisions is impossible; (2) preemption is express and unequivocal in the language of the federal statute; and (3)

congressional preemptive intent is implicit in the overall scheme of federal and state regulation. *Highland Chateau, Inc. v. Minnesota Dep't of Pub. Welfare*, 356 ***869** N.W.2d 804, 809-10 (Minn.App.1984), *review denied* (Minn. Feb. 6, 1985). The question in this case is whether compliance with both federal and state law is possible.

[3][4] The relevant federal statute provides:

> No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan * * *.

42 U.S.C. § 1396p(a)(1) (1994). Another federal provision, however, directs the states to require that an individual receiving medical assistance must assign his rights to "payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A) (1994).

The state lien statute provides that the state shall have a lien for the cost of medical care against "any and all causes of action." Minn.Stat. § 256.015 Supp.1999). Respondent asserts that this provision violates the foregoing federal statute because it provides for a lien against the property of Hoff before his death. Respondent argues that, although the state may seek reimbursement directly from a third party who is legally liable for the injuries resulting in medical care, it may not proceed as it did in the instant case by asserting a lien against the recipient's "property", i.e., their cause of action.

> FN 1. The lien provision, in relevant part, reads:
> When the state agency provides, pays for, or becomes liable for medical care or furnishes subsistence or other payments to a person, the agency shall have a lien for the cost of the care and payments on any and all causes of action or recovery rights under any policy, plan, or contract providing benefits for health care or injury which accrue to the person to whom the care or

> payments were furnished, or to the person's legal representatives, as a result of the occurrence that necessitated the medical care, subsistence, or other payments.
>
> Minn.Stat. § 256.015, subd. 1 (Supp.1999). A similar provision is found at Minn.Stat. § 256B.042, subd. 1 (Supp.1999).

The Utah Supreme Court recently addressed this issue in *Wallace v. Estate of Jackson*, 972 P.2d 446 Utah 1998), *cert. denied*, --- U.S. ----, 120 S.Ct. 42, 145 L.Ed.2d 38 (1999), and a companion case, *S.S. v. State*, 972 P.2d 439 (Utah 1998). The Utah court was presented with a challenge to the state's ability to assert liens against a Medicaid recipient's third-party tort recovery. That court upheld the statute by finding that

> payments made by a third party do not legally become the property of the recipient until after a valid settlement which must include reimbursement to the State for Medicaid benefits.

Wallace, 972 P.2d at 448.

In upholding the Utah lien statute, the Utah court relied in part on a decision by the New York Court of Appeals in *Cricchio v. Pennisi*, 90 N.Y.2d 296, 660 N.Y.S.2d 679, 683 N.E.2d 301 (1997), which stated that

> settlement proceeds are resources of the third-party tortfeasor that are owed to [the state]. Accordingly, the lien on the settlement proceeds attaches to the property of the third party, and thus does not violate the statutory prohibition against imposing a lien against a beneficiary's property until after his or her death. The flaw in plaintiffs' theory that the lien cannot be satisfied until the recipient's death is that it fails to appreciate this critical distinction between the assets of a responsible third party and assets belonging to the Medicaid recipient.

Id. at 305 (citations omitted).

The Second Circuit recently reached the same result, but on a rationale we find more persuasive. The Second Circuit stated:

> Pursuant to federal law, Medicaid recipients must assign to the state their rights to seek and collect payment for medical care from a responsible third party. As part of its recoupment power, the [state agency] administering Medicaid may ***870** place a lien on the Medicaid recipient's personal injury claims against a tortfeasor in order to recover the agency's medical expenditures. [These] liens enjoy a specific exemption from the general rule that the state may not encumber a Medicaid recipient's property prior to death.

Sullivan v. County of Suffolk, 174 F.3d 282, 285 (2d Cir.1999), *cert. denied*, --- U.S. ----, 120 S.Ct. 372, 145 L.Ed.2d 290 (1999) (citations omitted).

In *Norwest Bank v. Doth*, 159 F.3d 328 (8th Cir.1998), the Eighth Circuit, while applying Minnesota law, found that

> a state may require a Medicaid lien imposed on the proceeds of a personal injury award or settlement to be satisfied before the remaining funds are placed in [a trust].

Id. at 333. The Eighth Circuit, however, declined to address the specific preemption issue before this court.

The Minnesota medical-assistance-recovery statute contemplates alternative procedures that the state may utilize to recover reimbursement of medical assistance. The state may either bring its own action or impose a lien on any recovery the medical-assistance recipient might gain in the recipient's own action. The lien is simply a device to protect the state's legitimate subrogation interest. This lien does not have the effect of allowing the state to make a claim on property that is not connected to the medical assistance it has provided. Further, the lien allowance does not prevent all

recovery to the injured party. Under the lien procedure, the plaintiff is guaranteed "at least one-third of the net recovery after attorney fees and other collection costs." Minn.Stat. § 256.015, subd. 5 (1998). [FN2]

> FN2. The provision, in relevant part, reads: "The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and other collection costs." Minn.Stat. § 256.015, subd. 5.

Minnesota's medical-assistance statute, thus, does not conflict with the federal Medicaid statutory scheme. *See In re Estate of Turner*, 391 N.W.2d 767, 770 (Minn.1986) (medical assistance serves system "whereby money paid to qualified individuals for health care purposes may be recovered and reused to help other similarly situated persons").

II.

[5][6] Respondent asks this court to strike a portion of appellant's appendix. The challenged materials consist of: (1) the testimony of Mike Hash, Deputy Administrator for HCFA, before the Senate Appropriations Subcommittee on Labor, HHS, Education, and related agencies dated March 15, 1999; (2) a pamphlet titled "Third Party Liability in the Medicaid Program," a guide to successful state-agency practices; and (3) the State Medicaid Manual. This information consists only of general information concerning Minnesota's medical-assistance program and is a matter of public record.

> [There is] no reason why a party may not submit such a report to us as part of its brief when we could refer to such a report in the course of our own research, if we were so inclined.

See id. at 771 (denying motion to strike report consisting of general information about state medical assistance finding it

matter of public record). Accordingly, respondent's motion to strike that portion of appellant's appendix is denied.

DECISION

Minnesota's medical-assistance-lien statute is not in conflict with federal law. The third-party tort settlement is subject to a state subrogation claim for medical assistance that has been paid. Under state law, the subrogation claim may be protected by a lien.

Reversed.

615 N.W.2d 867

STATE OF MINNESOTA

COUNTY OF OLMSTED

DISTRICT COURT
CIVIL DIVISION
THIRD JUDICIAL DISTRICT

Joan Martin, guardian ad litem for Troy Hoff

Plaintiffs,

and

State of Minnesota,

Plaintiff on Impleader,

vs.

City of Rochester, Rochester Township, and Estate of Donald Tlougan,

Defendants.

Personal Injury

Court File No: C2-94-498

AMENDED FINDINGS OF FACT, CONCLUSIONS OF LAW, ORDER FOR JUDGMENT AND JUDGMENT

The above-entitled matter came on before the Court on the 29th day of September, 1999 in the courtroom in the courthouse at Rochester, Minnesota. Appearing on behalf of the plaintiff Joan Martin were Charles A. Bird and Jason Schmickle of Bird & Jacobsen, Rochester, Minnesota; appearing on behalf of plaintiff on impleader, State of Minnesota, were Gail Feichtinger and Suzette Schommer from the Office of The Attorney General, St. Paul, Minnesota; appearing on behalf of defendant Estate of Donald Tlougan was attorney Robert Spelhaug, Rochester, Minnesota. There

were no other appearances. The matter to be considered at that time was plaintiff's motion to strike any claim of the State of Minnesota to a portion of the settlement proceeds of plaintiff Joan Martin's settlements with defendants. The Court, being duly advised in the premises and having reviewed all of the files and records herein, including the memoranda and affidavits submitted by counsel, and having further listened to the oral arguments of counsel, now makes the following:

FINDINGS OF FACT

1. On July 10, 1991, Troy Hoff was involved in a motor vehicle accident in Rochester, Minnesota. As a result thereof, he suffered a serious brain injury, which has left him permanently and totally disabled as well as mentally incompetent;

2. Thereafter, the State of Minnesota made Medical Assistance payments on behalf of Troy Hoff pursuant to the provisions of Minn. Stat. §256B.01 et seq. and 42 U.S.C.§1396. Said payments commenced on November 25, 1991;

3. On May 23, 1993, Joan E. Martin, on, behalf of Troy Hoff, her son, signed an application for Medical Assistance and, at that time made a medical assignment, as mandated by 42 U.S.C. §1396k, which stated as follows:

> As a condition of eligibility for Medical Assistance, I assign to the State of Minnesota any rights available to me under automobile or private health care coverage and any rights to payment for medical care from any third party for myself or my dependents. I agree to cooperate with the State in any legal action brought against a third party for payment of medical expenses or subsistence.

Following execution of such assignment, neither Joan Martin nor Troy Hoff had any right and no obligation to pursue a

cause of action against third parties for medical expenses of Troy Hoff which had been paid or which were thereafter paid by the State of Minnesota Department of Human Services;

4. The instant action was commenced by plaintiff Joan Martin on behalf of Troy Hoff on or about September 2, 1993, at which time the State of Minnesota was involuntarily joined as a plaintiff on impleader.

5. 42 U.S.C. §1396p(a) provides:

> No lien may be imposed against the property of any individual prior to his death on account of Medical Assistance paid or to be paid on his behalf under the estate plan...

6. In spite of this provision of federal law, the State of Minnesota filed a lien in the offices of the Olmsted County Record on June 21, 1993, said lien being placed upon the cause of action of Troy Hoff pursuant to the provisions of Minn. Stat. §256B.042, subd.1, which states, in pertinent part:

> When the state agency provides, pays for, or becomes liable for medical care, it shall have a lien for the cost of the care upon any and all causes of action....which accrue to the person to whom the care was furnished, or to the person's legal representatives as a result of the illness or injuries which necessitated the medical care;

7. The plain meaning of the federal regulatory scheme set out in 42 U.S.C.§1396, including the anti-lien provision set out at §1396p(a) and the assignment provision at § 1396k, both independently and read *in pari materia* prohibit the imposition of a lien on any property of Troy Hoff until his death.

8. The cause of action commenced on behalf of Troy Hoff on or about September 3, 1993, by his mother Joan Martin, was the sole and exclusive property of Troy Hoff;

9. That the plain meaning of Minn. Stat. §256B.042, subd.1, seeks to impose a lien on the cause of action accruing

to Troy Hoff in this case, which cause of action was property exclusively owned by Troy Hoff;

10. The State of Minnesota Medical Assistance plan must conform to the requirements of federal law. Schweiker v. Gray Panthers, 453 U.S. 34,37 (1981). If the State's Medical Assistance statute fails to conform with federal law, it must be invalidated to the extent necessary to harmonize the state scheme with federal law. Dalton v. Little Rock Family Planning Services, 516 U.S. 474, 476 (1996); Union Center Redevelopment Corp. v. National Railroad Passenger Corp., 103 F.3d 62, 64 (8th Circ. 1997). The relevant state statute in this case, 256B.042, subd.1, and related state statutes including Minn. Stat. §256.015 and §256B.37 do not conform with the requirements of federal law and therefore must be invalidated in order to harmonize the state scheme with the federal scheme outlined above;

11. Joan Martin, on behalf of Troy Hoff by and through her attorneys negotiated settlements totalling $220,000 in settlement of Troy Hoff's cause of action for personal injuries;

12. The State of Minnesota, though they were impleaded as a party plaintiff did not independently pursue their cause of action for medical benefits provided to Troy Hoff, which claims had been assigned to the State of Minnesota by Joan Martin as noted above;

13. The Court finds as fact that the settlement proceeds of $220,000 from the three defendants in this action was, and at all times remains, the sole and exclusive property of Troy Hoff;

14. That the State of Minnesota may not avoid the plain meaning of the provisions of federal law noted above by claiming that the settlement proceeds were the property of a third person. The State of Minnesota has provided no rational explanation to support such argument. Moreover, such an interpretation would be incompatible with the underlying purpose of such federal legislation, which is to preserve the property of Medical Assistance recipients

during their lifetime, thereby lessening the burden upon persons who have no ability to pay for medical care.

15. That the State's claim to these recovery proceeds based upon the subrogation provision of Minnesota law (Minn. Stat. §256B.37) is rejected because (a) the State failed to timely assert a claim for subrogation and (b) even if such claim had been timely asserted, such claim would also be prohibited by the plain meaning of the anti-lien provisions in the federal scheme.

CONCLUSIONS OF LAW

1. Minn. Stat. §§256B.042, 256.015 and 256B.37 are invalidated to the extent that they permit the State of Minnesota to place a lien on a cause of action or attempt to recover any part of the proceeds of such causes of action accruing to the person to whom the care was furnished arising out of the injuries which necessitated the medical care and the State of Minnesota is hereby prohibited from enforcing such provisions;

2. The settlement proceeds in this action which have been or will be deposited with the Olmsted County Court Administrator and any accrued interest are the sole and exclusive property of Troy Hoff, and such proceeds shall be paid to the trustee of a trust for the benefit of Troy Hoff established pursuant to the provisions of 42 U.S.C. §1396p(d)(4). Until such trust is established, the State of Minnesota is prohibited from including any assets or income from said moneys in determining the eligibility of Troy Hoff for Medical Assistance services;

3. Notwithstanding the immediately preceding paragraph, the settlement proceeds referred to above shall be retained by said Court Administrator until either the expiration of the time to appeal from this Order or until the exhaustion of any and all appeals that may arise out of this Order, whichever is later.

4. The request of the plaintiff for an award of attorneys' fees and expenses pursuant to Minn. Stat. § 15.471 is deferred until either the expiration of the time to appeal from this Order or the exhaustion of any and all appeals that may arise out of this Order, whichever is later. At such time, the plaintiff, Joan Martin, may renew her request for an award of attorneys' fees.

5. There being no just reason for delay, this Court orders entry of judgment in this matter as allowed under Rule 54.02 of the Minnesota Rules of Civil Procedure.

Dated this 29 day of February, 2000.

BY THE COURT:

s/
Honorable James L. Mork
Judge of District Court

JUDGMENT

I HEREBY certify that the foregoing Conclusions of Law constitute the Judgment of the Court.

Dated this 29 day of Feb., 2000.

JOHN M. POWELL
COURT ADMINISTRATOR

s/Gayla Rahn
Deputy Perk

STATE OF MINNESOTA

IN SUPREME COURT

C3-00-398

Joan Martin, guardian ad litem
for Troy Hoff, petitioner,

Appellant,

and ORDER

State of Minnesota, plaintiff on impleader,

Respondent,

vs.

City of Rochester, et al.,

Defendants.

Based upon all the files, records and proceedings herein,

IT IS HEREBY ORDERED THAT the petition for rehearing in the above-entitled matter be, and the same is, denied.

DATED: April 23, 2002.

BY THE COURT:

s/_____
PAUL H. ANDERSON
ASSOCIATE JUSTICE

-EXPCITE-

TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 7 - SOCIAL SECURITY

SUBCHAPTER XIX - GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

-HEAD-

Sec. 1396a. State plans for medical assistance

-STATUTE-

(a) Contents
A State plan for medical assistance must -

* * *

(25) provide -

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(1))), service benefit plans, and health maintenance organizations) to pay for care and services available under the plan, including -

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title) exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall -

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall –

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(1)), a service benefit plan, and a health maintenance organization), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this subchapter for such State, or any other State; and

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

* * *

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title[.]

-EXPCITE-

TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 7 - SOCIAL SECURITY

SUBCHAPTER XIX - GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

-HEAD-

Sec. 1396k. Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

-STATUTE-

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall -

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required -

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in section 1396a(l)(1)(A) of this title or the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 654(3) of this title) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to

reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

-EXPCITE-

TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 7 - SOCIAL SECURITY

SUBCHAPTER XIX - GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

-HEAD-

Sec. 1396p. Liens, adjustments and recoveries, and transfers of assets

-STATUTE-

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except -

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual -

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home, except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if -

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B) of this section, the State shall seek

adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of -

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan.

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, which provided for the disregard of any assets or resources-

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the

individual's surviving spouse, if any, and only at a time -

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B) of this section, when -

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution), is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(4) For purposes of this subsection, the term "estate", with respect to a deceased individual -

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(c) Taking into account certain transfers of assets

(1)(A) In order to meet the requirements of this subsection for purposes of section 1396a(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or

(3)(B)(ii) of subsection (d) of this section, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to -

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1396n of this title.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1396d(a) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D) The date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(E)(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to -

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to -

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced -

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that -

(A) the assets transferred were a home and title to the home was transferred to -

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets -

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section)

established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary; (FOOTNOTE 1)

(FOOTNOTE 1) So in original. The semicolon probably should be a period.

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1396a(f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market

value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term ''resources'' has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

(d) Treatment of trust amounts

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to -

(i) the purposes for which a trust is established,

(ii) whether the trustees have or exercise any discretion under the trust,

(iii) any restrictions on when or whether distributions may be made from the trust, or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust -

(i) the corpus of the trust shall be considered resources available to the individual,

(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c) of this section.

(B) In the case of an irrevocable trust -

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income -

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c) of this section; and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c) of this section, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

(B) A trust established in a State for the benefit of an individual if -

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter; and

(iii) the State makes medical assistance available to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a(a)(10)(C) of this title.

(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

(i) The trust is established and managed by a non-profit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an

annuity only to such extent and in such manner as the Secretary specifies.

(e) Definitions

In this section, the following definitions shall apply: (1) The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action -

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1382a of this title.

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title.

(4) The term "noninstitutionalized individual" means an individual receiving any of the services specified in subsection (c)(1)(C)(ii) of this section.

(5) The term "resources" has the meaning given such term in section 1382b of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

42 CFR § 430.0
42 C.F.R. § 430.0

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 430--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS SUBPART A--INTRODUCTION; GENERAL PROVISIONS

Current through June 17, 2002; 67 FR 41204

§ 430.0 Program description.

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 430.0

42 CFR § 430.0

42 CFR § 430.10
42 C.F.R. § 430.10

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 430--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS SUBPART B--STATE PLANS

Current through June 17, 2002; 67 FR 41204

§ 430.10 The State plan.

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 430.10

42 CFR § 430.10

42 CFR § 430.15
42 C.F.R. § 430.15

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 430--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS SUBPART B--STATE PLANS

Current through June 17, 2002; 67 FR 41204

§ 430.15 Basis and authority for action on State plan material.

(a) Basis for action.

(1) Determinations as to whether State plans (including plan amendments and administrative practice under the plans) originally meet or continue to meet the requirements for approval are based on relevant Federal statutes and regulations.

(2) Guidelines are furnished to assist in the interpretation of the regulations.

(b) Approval authority. The Regional Administrator exercises delegated authority to approve the State plan and plan amendments on the basis of policy statements and precedents previously approved by the Administrator.

(c) Disapproval authority.

(1) The Administrator retains authority for determining that proposed plan material is not approvable or that previously approved material no longer meets the requirements for approval.

(2) The Administrator does not make a final determination of disapproval without first consulting the Secretary.

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 430.15

42 CFR § 430.15

42 CFR § 430.35
42 C.F.R. § 430.35

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 430--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS SUBPART C--GRANTS; REVIEWS AND AUDITS; WITHHOLDING FOR FAILURE TO COMPLY; DEFERRAL AND DISALLOWANCE OF CLAIMS; REDUCTION OF FEDERAL MEDICAID PAYMENTS

Current through June 17, 2002; 67 FR 41204

§ 430.35 Withholding of payment for failure to comply with Federal requirements.

(a) Basis for withholding. CMS withholds payments to the State, in whole or in part, only if, after given the agency reasonable notice and opportunity for a hearing in accordance with Subpart D of this part, the Administrator finds--

(1) That the plan no longer complies with the provisions of section 1902 of the Act; or

(2) That in the administration of the plan there is failure to comply substantially with any of those provisions.

(Hearings under Subpart D are generally not called until a reasonable effort has been made to resolve the issues through conferences and discussions. These may be continued even if a date and place have been set for the hearing.)

(b) Noncompliance of the plan. A question of noncompliance of a State plan may arise from an unapprovable change in the approved State plan or the failure of the State to change its approved plan to conform to a new Federal requirement for approval of State plans.

(c) Noncompliance in practice. A question of noncompliance in practice may arise from the State's failure to actually comply with a Federal requirement, regardless of whether the plan itself complies with that requirement.

(d) Notice and implementation of withholding. If the Administrator makes a finding of noncompliance under paragraph (a) of this section, the following rules apply:

(1) The Administrator notifies the State:

(i) That no further payments will be made to the State (or that payments will be made only for those portions or aspects of the program that are not affected by the noncompliance); and

(ii) That the total or partial withholding will continue until the Administrator is satisfied that the State's plan and practice are, and will continue to be, in compliance with Federal requirements.

(2) CMS withholds payments, in whole or in part, until the Administrator is satisfied regarding the State's compliance.

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 430.35

42 CFR § 430.35

42 CFR § 433.135
42 C.F.R. § 433.135

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 433--STATE FISCAL ADMINISTRATION SUBPART D--THIRD PARTY LIABILITY

Current through June 17, 2002; 67 FR 41204

§ 433.135 Basis and purpose.

This subpart implements sections 1902(a)(25), 1902(a)(45), 1903(d)(2), 1903(o), 1903(p), and 1912 of the Act by setting forth State plan requirements concerning—

(a) The legal liability of third parties to pay for services provided under the plan;

(b) Assignment to the State of an individual's rights to third party payments; and

(c) Cooperative agreements between the Medicaid agency and other entities for obtaining third party payments.

[50 FR 46664, Nov. 12, 1985]

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 433.135

42 CFR § 433.135

42 CFR § 433.137
42 C.F.R. § 433.137

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 433--STATE FISCAL ADMINISTRATION SUBPART D--THIRD PARTY LIABILITY

Current through June 17, 2002; 67 FR 41204

§ 433.137 State plan requirements.

(a) A State plan must provide that the requirements of § § 433.138 and 433.139 are met for identifying third parties liable for payment of services under the plan and for payment of claims involving third parties.

(b) A State plan must provide that--

(1) The requirements of § § 433.145 through 433.148 are met for assignment of rights to benefits, cooperation with the agency in obtaining medical support of payments, and cooperation in identifying and providing information to assist the State in pursuing any liable third parties; and

(2) The requirements of § § 433.151 through 433.154 are met for cooperative agreements and incentive payments for third party collections.

(c) The requirements of paragraph (b)(1) of this section relating to assignment of rights to benefits and cooperation in obtaining medical support or payments and paragraph (b)(2) of this section are effective for medical assistance furnished on or after October 1, 1984. The requirements of paragraph (b)(1) of this section relating to cooperation in

identifying and providing information to assist the State in pursuing liable third parties are effective for medical assistance furnished on or after July 1, 1986.

[50 FR 46665, Nov. 12, 1985; 55 FR 48606, Nov. 21, 1990; 55 FR 52130, Dec. 19, 1990; 60 FR 35502, July 10, 1995]

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 433.137

42 CFR § 433.137

42 CFR § 433.138
42 C.F.R. § 433.138

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 433--STATE FISCAL ADMINISTRATION SUBPART D--THIRD PARTY LIABILITY

Current through April 1, 2002; 67 FR 15461

§ 433.138 Identifying liable third parties.

(a) Basic provisions. The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (k) of this section, unless waived under paragraph (l) of this section.

(b) Obtaining health insurance information: Initial application and redetermination processes for Medicaid eligibility.

(1) If the Medicaid agency determines eligibility for Medicaid, it must, during the initial application and each redetermination process, obtain from the applicant or recipient such health insurance information as would be useful in identifying legally liable third party resources so that the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f). Health insurance information may include, but is not limited to, the name of the policy holder, his or her relationship to the applicant or recipient, the social security number (SSN) of the policy holder, and the name and address of insurance company and policy number.

(2) If Medicaid eligibility is determined by the Federal agency administering the supplemental security income program under title XVI in accordance with a written agreement under section 1634 of the Act, the Medicaid agency must take the following action. It must enter into an agreement with CMS or must have, prior to February 1, 1985, executed a modified section 1634 agreement that is still in effect to provide for--

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of health insurance information in the form and manner specified by the Secretary; and

(ii) Transmittal of the information to the Medicaid agency.

(3) If Medicaid eligibility is determined by any other agency in accordance with a written agreement, the Medicaid agency must modify the agreement to provide for--

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of such health insurance information as would be useful in identifying legally liable third party resources so that the Medicaid agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f). Health insurance information may include, but is not limited to, those elements described in paragraph (b)(1) of this section; and

(ii) Transmittal of the information to the Medicaid agency.

(c) Obtaining other information. Except as provided in paragraph (l) of this section, the agency must, for the purpose of implementing the requirements in paragraphs (d)(1)(ii) and (d)(4)(i) of this section, incorporate into the

eligibility case file the names and SSNs of absent or custodial parents of Medicaid recipients to the extent such information is available.

(d) Exchange of data. Except as provided in paragraph (l) of this section, to obtain and use information for the purpose of determining the legal liability of the third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f), the agency must take the following actions:

(1) Except as specified in paragraph (d)(2) of this section, as part of the data exchange requirements under § 435.945 of this chapter, from the State wage information collection agency (SWICA) defined in § 435.4 of this chapter and from the SSA wage and earnings files data as specified in § 435.948(a)(2) of this chapter, the agency must—

(i) Use the information that identifies Medicaid recipients that are employed and their employer(s); and

(ii) Obtain and use, if their names and SSNs are available to the agency under paragraph (c) of this section, information that identifies employed absent or custodial parents of recipients and their employer(s).

(2) If the agency can demonstrate to CMS that it has an alternate source of information that furnishes information as timely, complete and useful as the SWICA and SSA wage and earnings files in determining the legal liability of third parties, the requirements of paragraph (d)(1) of this section are deemed to be met.

(3) The agency must request, as required under § 435.948(a)(6)(i), from the State title IV-A agency, information not previously reported that identifies those Medicaid recipients that are employed and their employer(s).

(4) Except as specified in paragraph (d)(5) of this section, the agency must attempt to secure agreements (to the extent permitted by State law) to provide for obtaining--

(i) From State Workers' Compensation or Industrial Accident Commission files, information that identifies Medicaid recipients and, (if their names and SSNs were available to the agency under paragraph (c) of this section) absent or custodial parents of Medicaid recipients with employment-related injuries or illnesses; and

(ii) From State Motor Vehicle accident report files, information that identifies those Medicaid recipients injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists.

(5) If unable to secure agreements as specified in paragraph (d)(4) of this section, the agency must submit documentation to the regional office that demonstrates the agency made a reasonable attempt to secure these agreements. If CMS determines that a reasonable attempt was made, the requirements of paragraph (d)(4) of this section are deemed to be met.

(e) Diagnosis and trauma code edits.

(1) Except as specified under paragraph (e)(2) or (l) of this section, or both, the agency must take action to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 International Classification of Disease, 9th Revision, Clinical Modification, Volume 1 (ICD- 9-CM) inclusive, for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f).

(2) The agency may exclude code 994.6, Motion Sickness, from the edits required under paragraph (e)(1) of this section.

(f) Data exchanges and trauma code edits: Frequency. Except as provided in paragraph (l) of this section, the agency must conduct the data exchanges required in paragraphs (d)(1) and (d)(3) of this section in accordance with the intervals specified in § 435.948 of this chapter, and diagnosis and trauma edits required in paragraphs (d)(4) and (e) of this section on a routine and timely basis. The State plan must specify the frequency of these activities.

(g) Follow-up procedures for identifying legally liable third party resources. Except as provided in paragraph (l) of this section, the State must meet the requirements of this paragraph.

(1) SWICA, SSA wage and earnings files, and title IV-A data exchanges. With respect to information obtained under paragraphs (d)(1) through (d)(3) of this section--

(i) Except as specified in § 435.952(d) of this chapter, within 45 days, the agency must followup (if appropriate) on such information in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(1)(i) of this section.

(2) Health insurance information and workers' compensation data exchanges. With respect to information obtained under paragraphs (b) and (d)(4)(i) of this section--

(i) Within 60 days, the agency must followup on such information (if appropriate) in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(2)(i) of this section.

(3) State motor vehicle accident report file data exchanges. With respect to information obtained under paragraph (d)(4)(ii) of this section--

(i) The State plan must describe the methods the agency uses for following up on such information in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify timeframes for incorporation of the information.

(4) Diagnosis and trauma code edits. With respect to the paid claims identified under paragraph (e) of this section--

(i) The State plan must describe the methods the agency uses to follow up on such claims in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f) (Methods must include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes.);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify the timeframes for incorporation of the information.

(h) Obtaining other information and data exchanges: Safeguarding information.

(1) The agency must safeguard information obtained from and exchanged under this section with other agencies in accordance with the requirements set forth in Part 431, Subpart F of this chapter.

(2) Before requesting information from, or releasing information to other agencies to identify legally liable third party resources under paragraph (d) of this section the agency must execute data exchange agreements with those agencies. The agreements, at a minimum, must specify--

(i) The information to be exchanged;

(ii) The titles of all agency officials with the authority to request third party information;

(iii) The methods, including the formats to be used, and the timing for requesting and providing the information;

(iv) The safeguards limiting the use and disclosure of the information as required by Federal or State law or regulations; and

(v) The method the agency will use to reimburse reasonable costs of furnishing the information if payment is requested.

(i) Reimbursement. The agency must, upon request, reimburse an agency for the reasonable costs incurred in furnishing information under this section to the Medicaid agency.

(j) Reports. The agency must provide such reports with respect to the data exchanges and trauma code edits set forth in paragraphs (d)(1) through (d)(4) and paragraph (e) of this section, respectively, as the Secretary prescribes for the purpose of determining compliance under § 433.138 and evaluating the effectiveness of the third party liability identification system. However, if the State is not meeting the provisions of paragraph (e) of this section because it has been granted a waiver of those provisions under paragraph (1) of this section, it is not required to provide the reports required in this paragraph.

(k) Integration with the State mechanized claims processing and information retrieval system. Basic requirement--Development of an action plan.

(1) If a State has a mechanized claims processing and information retrieval system approved by CMS under Subpart C of this part, the agency must have an action plan for pursuing third party liability claims and the action plan must be integrated with the mechanized claims processing and information retrieval system.

(2) The action plan must describe the actions and methodologies the State will follow to--

(i) Identify third parties;

(ii) Determine the liability of third parties;

(iii) Avoid payment of third party claims as required in § 433.139;

(iv) Recover reimbursement from third parties after Medicaid claims payment as required in § 433.139; and,

(v) Record information and actions relating to the action plan.

(3) The action plan must be consistent with the conditions for reapproval set forth in § 433.119. The portion of the plan which is integrated with MMIS is monitored in accordance with those conditions and if the conditions are not met; it is subject to FFP reduction in accordance with procedures set forth in § 433.120. The State is not subject to any other penalty as a result of other monitoring, quality control, or auditing requirements for those items in the action plan.

(4) The agency must submit its action plan to the CMS Regional Office within 120 days from the date CMS issues implementing instructions for the State Medicaid Manual. If a State does not have an approved MMIS on the date of issuance of the State Medicaid Manual but subsequently implements an MMIS, the State must submit its action plan within 90 days from the date the system is operational. The CMS Regional Office approves or disapproves the action plan.

(l) Waiver of requirements.

(1) The agency may request initial and continuing waiver of the requirements to determine third party liability found in paragraphs (c), (d)(4), (d)(5), (e), (f), (g)(1), (g)(2), (g)(3), and (g)(4) of this section if the State determines the activity to be not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the CMS regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are claims recovery data and a State analysis documenting a cost-effective alternative that accomplished the same task.

(iii) The agency must agree, if a waiver is granted, to notify CMS of any event that occurs that changes the conditions upon which the waiver was approved.

(2) CMS will review a State's request to have a requirement specified under paragraph (l)(1) of this section waived and will request additional information from the State, if necessary. CMS will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) CMS may rescind a waiver at any time that it determines that the agency no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

[52 FR 5975, Feb. 27, 1987; 54 FR 8741, March 2, 1989; 55 FR 1432, Jan. 16, 1990; 55 FR 5118, Feb. 13, 1990; 60 FR 35502, July 10,1995]

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 433.138

42 CFR § 433.138

42 CFR § 433.139
42 C.F.R. § 433.139

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 433--STATE FISCAL ADMINISTRATION SUBPART D--THIRD PARTY LIABILITY

Current through April 1, 2002; 67 FR 15461

§ 433.139 Payment of claims.

(a) Basic provisions.

(1) For claims involving third party liability that are processed on or after May 12, 1986, the agency must use the procedures specified in paragraphs (b) through (f) of this section.

(2) The agency must submit documentation of the methods (e.g., cost avoidance, pay and recover later) it uses for payment of claims involving third party liability to the CMS Regional Office.

(b) Probable liability is established at the time claim is filed. Except as provided in paragraph (e) of this section--

(1) If the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency must then pay

the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

(2) The agency may pay the full amount allowed under the agency's payment schedule for the claim and then seek reimbursement from any liable third party to the limit of legal liability if the claim is for labor and delivery and postpartum care. (Costs associated with the inpatient hospital stay for labor and delivery and postpartum care must be cost-avoided.)

(3) The agency must pay the full amount allowed under the agency's payment schedule for the claim and seek reimbursement from any liable third party to the limit of legal liability (and for purposes of paragraph (b)(3)(ii) of this section, from a third party, if the third party liability is derived from an absent parent whose obligation to pay support is being enforced by the State title IV-D agency), consistent with paragraph (f) of this section if--

(i) The claim is prenatal care for pregnant women, or preventive pediatric services (including early and periodic screening, diagnosis and treatment services provided for under part 441, subpart B of this chapter), that is covered under the State plan; or

(ii) The claim is for a service covered under the State plan that is provided to an individual on whose behalf child support enforcement is being carried out by the State title IV-D agency. The agency prior to making any payment under this section must assure that the following requirements are met:

(A) The State plan specifies whether or not providers are required to bill the third party.

(B) The provider certifies that before billing Medicaid, if the provider has billed a third party, the provider has waited 30 days from the date of the service and has not received payment from the third party.

(C) The State plan specifies the method used in determining the provider's compliance with the billing requirements.

(c) Probable liability is not established or benefits are not available at the time claim is filed. If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the agency must pay the full amount allowed under the agency's payment schedule.

(d) Recovery of reimbursement.

(1) If the agency has an approved waiver under paragraph (e) of this section to pay a claim in which the probable existence of third party liability has been established and then seek reimbursement, the agency must seek recovery of reimbursement from the third party to the limit of legal liability within 60 days after the end of the month in which payment is made unless the agency has a waiver of the 60-day requirement under paragraph (e) of this section.

(2) Except as provided in paragraph (e) of this section, if the agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid, the agency must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party or benefits become available.

(3) Reimbursement must be sought unless the agency determines that recovery would not be cost effective in accordance with paragraph (f) of this section.

(e) Waiver of requirements.

(1) The agency may request initial and continuing waiver of the requirements in paragraphs (b)(1), (d)(1), and (d)(2) of this section, if it determines that the requirement is not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the CMS regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are costs associated with billing, claims recovery data, and a State analysis documenting a cost-effective alternative that accomplishes the same task.

(iii) The agency must agree, if a waiver is granted, to notify CMS of any event that occurs that changes the conditions upon which the waiver was approved.

(2) CMS will review a State's request to have a requirement specified under paragraph (e)(1) of this section waived and will request additional information from the State, if necessary. CMS will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) CMS may rescind the waiver at any time that it determines that the State no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

(4) An agency requesting a waiver of the requirements specifically concerning either the 60-day limit in paragraph (d)(1) or (d)(2) of this section must submit documentation of written agreement between the agency and the third party, including Medicare fiscal intermediaries and carriers, that extension of the billing requirement is agreeable to all parties.

(f) Suspension or termination of recovery of reimbursement.

(1) An agency must seek reimbursement from a liable third party on all claims for which it determines that the amount it reasonably expects to recovery will be greater than the cost of recovery. Recovery efforts may be suspended or terminated only if they are not cost effective.

(2) The State plan must specify the threshold amount or other guideline that the agency uses in determining whether to seek recovery of reimbursement from a liable third party, or describe the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

(3) The State plan must also specify the dollar amount or period of time for which it will accumulate billings with respect to a particular liable third party in making the decision whether to seek recovery of reimbursement.

(43 FR 45201, Sept. 29, 1978, as amended at 46 FR 48560, Oct. 1, 1981 50 FR 46665, Nov. 12, 1985; 51 FR 16319, May 2, 1986;

55 FR 1432, Jan. 16, 1990; 55 FR 5118, Feb. 13, 1990; 60 FR 35503, July 10, 1995; 62 FR 23140, April 29, 1997]

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 433.139

42 CFR § 433.139

42 CFR § 433.140
42 C.F.R. § 433.140

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 433--STATE FISCAL ADMINISTRATION SUBPART D--THIRD PARTY LIABILITY

Current through June 17, 2002; 67 FR 41204

§ 433.140 FFP and repayment of Federal share.

(a) FFP is not available in Medicaid payments if--

(1) The agency failed to fulfill the requirements of § § 433.138 and 433.139 with regard to establishing liability and seeking reimbursement from a third party;

(2) The agency received reimbursement from a liable third party; or

(3) A private insurer would have been obligated to pay for the service except that its insurance contract limits or excludes payments if the individual is eligible for Medicaid.

(b) FFP is available at the 50 percent rate for the agency's expenditures in carrying out the requirements of this subpart.

(c) If the State receives FFP in Medicaid payments for which it receives third party reimbursement, the State must pay the Federal government a portion of the reimbursement determined in accordance with the FMAP for the State. This payment may be reduced by the total amount needed to meet the incentive payment in § 433.153.

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 433.140

42 CFR § 433.140

42 CFR § 433.145
42 C.F.R. § 433.145

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 433--STATE FISCAL ADMINISTRATION SUBPART D--THIRD PARTY LIABILITY ASSIGNMENT OF RIGHTS TO BENEFITS

Current through April 1, 2002; 67 FR 15461

§ 433.145 Assignment of rights to benefits--State plan requirements.

(a) A State plan must provide that, as a condition of eligibility, each legally able applicant or recipient is required to:

(1) Assign to the Medicaid agency his or her rights, or the rights of any other individual eligible under the plan for whom he or she can legally make an assignment, to medical support and to payment for medical care from any third party;

(2) Cooperate with the agency in establishing paternity and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in section 1902(l)(1)(A) of the Act (poverty level pregnant women), who are exempt from cooperating in establishing paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan,

unless the individual establishes good cause for not cooperating.

(b) A State plan must provide that the requirements for assignments, cooperation in establishing paternity and obtaining support, and cooperation in identifying and providing information to assist the State in pursuing any liable third party under § § 433.146 through 433.148 are met.

(c) A State plan must provide that the assignment of rights to benefits obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid.

[50 FR 46665, Nov. 12, 1985; 50 FR 49389, Dec. 2, 1985; 55 FR 48606, Nov. 21, 1990; 58 FR 4907, Jan. 19, 1993]

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 433.145

42 CFR § 433.145

42 CFR § 433.146
42 C.F.R. § 433.146

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 433--STATE FISCAL ADMINISTRATION SUBPART D--THIRD PARTY LIABILITY ASSIGNMENT OF RIGHTS TO BENEFITS

Current through April 1, 2002; 67 FR 15461

§ 433.146 Rights assigned; assignment method.

(a) Except as specified in paragraph (b) of this section, the agency must require the individual to assign to the State--

(1) His own rights to any medical care support available under an order of a court or an administrative agency, and any third party payments for medical care; and

(2) The rights of any other individual eligible under the plan, for whom he can legally make an assignment.

(b) Assignment of rights to benefits may not include assignment of rights to Medicare benefits.

(c) If assignment of rights to benefits is automatic because of State law, the agency may substitute such an assignment for an individual executed assignment, as long as the agency informs the individual of the terms and consequences of the State law.

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 433.146

42 CFR § 433.146

42 CFR § 433.147
42 C.F.R. § 433.147

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 433--STATE FISCAL ADMINISTRATION SUBPART D--THIRD PARTY LIABILITY ASSIGNMENT OF RIGHTS TO BENEFITS

Current through April 1, 2002; 67 FR 15461

§ 433.147 Cooperation in establishing paternity and in obtaining medical support and payments and in identifying and providing information to assist in pursuing third parties who may be liable to pay.

(a) Scope of requirement. The agency must require the individual who assigns his or her rights to cooperate in--

(1) Establishing paternity of a child born out of wedlock and obtaining medical support and payments for himself or herself and any other person for whom the individual can legally assign rights, except that individuals described in section 1902(l)(1)(A) of the Act (poverty level pregnant women) are exempt from these requirements involving paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and

(2) Identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan.

(b) Essentials of cooperation. As part of a cooperation, the agency may require an individual to--

(1) Appear at a State or local office designated by the agency to provide information or evidence relevant to the case;

(2) Appear as a witness at a court or other proceeding;

(3) Provide information, or attest to lack of information, under penalty of perjury;

(4) Pay to the agency any support or medical care funds received that are covered by the assignment of rights; and

(5) Take any other reasonable steps to assist in establishing paternity and securing medical support and payments, and in identifying and providing information to assist the State in pursuing any liable third party.

(c) Waiver of cooperation for good cause. The agency must waive the requirements in paragraphs (a) and (b) of this section if it determines that the individual has good cause for refusing to cooperate.

(1) With respect to establishing paternity of a child born out of wedlock or obtaining medical care support and payments, or identifying or providing information to assist the State in pursuing any liable third party for a child for whom the individual can legally assign rights, the agency must find the cooperation is against the best interests of the child, in accordance with factors specified for the Child Support Enforcement Program at 45 CFR part 232. If the State title IV-A agency has made a finding that good cause for refusal to cooperate does or does not exist, the Medicaid agency must adopt that finding as its own for this purpose.

(2) With respect to obtaining medical care support and payments for an individual and identifying and providing information to assist in pursuing liable third parties in any case not covered by paragraph (c)(1) of this section, the

agency must find that cooperation is against the best interests of the individual or the person to whom Medicaid is being furnished because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person.

(d) Procedures for waiving cooperation. With respect to establishing paternity, obtaining medical care support and payments, or identifying and providing information to assist the State in pursuing liable third parties for a child for whom the individual can legally assign rights, the agency must use the procedures specified for the Child Support Enforcement Program at 45 CFR part 232. With respect to obtaining medical care support and payments or to identifying and providing information to assist the State in pursuing liable third parties for any other individual, the agency must adopt procedures similar to those specified in 45 CFR part 232, excluding those procedures applicable only to children.

[55 FR 48606, Nov. 21, 1990; 58 FR 4907, Jan. 19, 1993]

42 CFR § 433.148
42 C.F.R. § 433.148

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 433--STATE FISCAL ADMINISTRATION SUBPART D--THIRD PARTY LIABILITY ASSIGNMENT OF RIGHTS TO BENEFITS

Current through April 1, 2002; 67 FR 15461

§ 433.148 Denial or termination of eligibility.

In administering the assignment of rights provision, the agency must:

(a) Deny or terminate eligibility for any applicant or recipient who--

(1) Refuses to assign his own rights or those of any other individual for whom he can legally make an assignment; or

(2) Refuses to cooperate as required, under § 433.147 (a) unless cooperation has been waived;

(b) Provide Medicaid to any individual who--

(1) Cannot legally assign his own rights; and

(2) Would otherwise be eligible for Medicaid but for the refusal, by a person legally able to assign his rights, to assign his rights or to cooperate as required by this subpart; and

(c) In denying or terminating eligibility, comply with the notice and hearing requirements of Part 431, Subpart E of this subchapter.

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 433.148
42 CFR § 433.148

42 CFR § 433.151
42 C.F.R. § 433.151

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 433--STATE FISCAL ADMINISTRATION SUBPART D--THIRD PARTY LIABILITY COOPERATIVE AGREEMENTS AND INCENTIVE PAYMENTS

Current through April 1, 2002; 67 FR 15461

§ 433.151 Cooperative agreements and incentive payments--State plan requirements.

For medical assistance furnished on or after October 1,1984--

(a) A State plan must provide for entering into written cooperative agreements for enforcement of rights to and collection of third party benefits with at least one of the following entities: The State title IV-D agency, any appropriate agency of any State, and appropriate courts and law enforcement officials. The agreements must be in accordance with the provisions of § 433.152.

(b) A State plan must provide that the requirements for making incentive payments and for distributing third party collections specified in § § 433.153 and 433.154 are met.

[50 FR 46665, Nov. 12, 1985; 50 FR 49389, Dec. 2, 1985]

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 433.151

42 CFR § 433.151

42 CFR § 433.152
42 C.F.R. § 433.152

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 433--STATE FISCAL ADMINISTRATION SUBPART D--THIRD PARTY LIABILITY COOPERATIVE AGREEMENTS AND INCENTIVE PAYMENTS

Current through April l, 2002; 67 FR 15461

§ 433.152 Requirements for cooperative agreements for third party collections.

(a) Except as specified in paragraph (b) of this section, the State agency may develop the specific terms of cooperative agreements with other agencies as it determines appropriate for individual circumstances.

(b) Agreements with title IV-D agencies must specify that the Medicaid agency will--

(1) Meet the requirements of the Office of Child Support Enforcement for cooperative agreements under 45 CFR Part 306; and

(2) Provide reimbursement to the IV-D agency only for those child support services performed that are not reimbursable by the Office of Child Support Enforcement under title IV-D of the Act and that are necessary for the collection of amounts for the Medicaid program.

[50 FR 46666, Nov. 12, 1985]

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 433.152

42 CFR § 433.152

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS
PART 433--STATE FISCAL ADMINISTRATION
SUBPART D--THIRD PARTY LIABILITY COOPERATIVE AGREEMENTS AND INCENTIVE PAYMENTS
Current through April 1, 2002; 67 FR 15461

§ 433.153 Incentive payments to States and political subdivisions.

(a) When payments are required. The agency must make an incentive payment to a political subdivision, a legal entity of the subdivision such as a prosecuting or district attorney or a friend of the court, or another State that enforces and collects medical support and payments for the agency.

(b) Amount and source of payment. The incentive payment must equal 15 percent of the amount collected, and must be made from the Federal share of that amount.

(c) Payment to two or more jurisdictions. If more than one State or political subdivision is involved in enforcing and collecting support and payments:

(1) The agency must pay all of the incentive payment to the political subdivision, legal entity of the subdivision, or another State that collected medical support and payments at the request of the agency.

(2) The political subdivision, legal entity or other State that receives the incentive payment must then divide the incentive payment equally with any other political

subdivisions, legal entities, or other States that assisted in the collection, unless an alternative allocation is agreed upon by all jurisdictions involved.

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 433.153

42 CFR § 433.153

42 CFR § 433.154
42 C.F.R. § 433.154

CODE OF FEDERAL REGULATIONS TITLE 42--PUBLIC HEALTH CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C--MEDICAL ASSISTANCE PROGRAMS PART 433--STATE FISCAL ADMINISTRATION SUBPART D--THIRD PARTY LIABILITY COOPERATIVE AGREEMENTS AND INCENTIVE PAYMENTS

Current through April 1, 2002; 67 FR 15461

§ 433.154 Distribution of collections.

The agency must distribute collections as follows--

(a) To itself, an amount equal to State Medicaid expenditures for the individual on whose right the collection was based.

(b) To the Federal Government, the Federal share of the State Medicaid expenditures, minus any incentive payment made in accordance with § 433.153.

(c) To the recipient, any remaining amount. This amount must be treated as income or resources under Part 435 or Part 436 of this subchapter, as appropriate.

<General Materials (GM) - References, Annotations, or Tables>

42 C. F. R. § 433.154

42 CFR § 433.154

MN ST § 256B.042
M.S.A. § 256B.042

MINNESOTA STATUTES ANNOTATED PUBLIC WELFARE AND RELATED ACTIVITIES CHAPTER 2568. MEDICAL ASSISTANCE FOR NEEDY PERSONS

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Current through End of 2001 1st Sp. Sess.

256B.042. Third party liability

Subdivision 1. Lien for cost of care. When the state agency provides, pays for, or becomes liable for medical care, it shall have a lien for the cost of the care upon any and all causes of action or recovery rights under any policy, plan, or contract providing benefits for health care or injury, which accrue to the person to whom the care was furnished, or to the person's legal representatives, as a result of the illness or injuries which necessitated the medical care. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (d), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing facilities under the alternative payment demonstration project under section 256B.434; and county- based purchasing entities under section 256B.692.

Subd. 2. Lien enforcement. (a) The state agency may perfect and enforce its lien by following the procedures set forth in sections 514.69, 514.70 and 514.71, and its verified lien statement shall be filed with the appropriate court administrator in the county of financial responsibility. The verified lien statement shall contain the following: the name and address of the person to whom medical care was

furnished, the date of injury, the name and address of the vendor or vendors furnishing medical care, the dates of the service, the amount claimed to be due for the care, and, to the best of the state agency's knowledge, the names and addresses of all persons, firms, or corporations claimed to be liable for damages arising from the injuries. This section shall not affect the priority of any attorney's lien.

(b) The state agency is not subject to any limitations period referred to in section 514.69 or 514.71 and has one year from the date notice is first received by it under subdivision 4, paragraph (c), even if the notice is untimely, or one year from the date medical bills are first paid by the state agency, whichever is later, to file its verified lien statement. The state agency may commence an action to enforce the lien within one year of (1) the date the notice required by subdivision 4, paragraph (c), is received or (2) the date the recipient's cause of action is concluded by judgment, award, settlement, or otherwise, whichever is later.

(c) If the notice required in subdivision 4 is not provided by any of the parties to the claim at any stage of the claim, the state agency will have one year from the date the state agency learns of the lack of notice to commence an action. If amounts on the claim or cause of action are paid and the amount required to be paid to the state agency under subdivision 5, is not paid to the state agency, the state agency may commence an action to recover on the lien against any or all of the parties or entities which have either paid or received the payments.

Subd. 3. The attorney general shall represent the commissioner to enforce the lien created under this section or, if no action has been brought, may initiate and prosecute an independent action on behalf of the commissioner against a person, firm, or corporation that may be liable to the person to whom the care was furnished.

Any prepaid health plan providing services under sections 256B.69, 256D.03, subdivision 4, paragraph (d), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county-based purchasing entity providing services under section 256B.692 may retain legal representation to enforce their lien created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

Subd. 4. Notice. The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable to pay part or all of the cost of medical care when the state agency has paid or become liable for the cost of that care. Notice must be given as follows:

(a) Applicants for medical assistance shall notify the state or local agency of any possible claims when they submit the application. Recipients of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A party to a claim upon which the state agency may be entitled to a lien under this section shall notify the state agency of its potential lien claim at each of the following stages of a claim:

(1) when a claim is filed;

(2) when an action is commenced; and

(3) when a claim is concluded by payment, award, judgment, settlement, or otherwise.

Every party involved in any stage of a claim under this subdivision is required to provide notice to the state agency at that stage of the claim. However, when one of the parties to the claim provides notice at that stage, every other party to the claim is deemed to have provided the required notice at that stage of the claim. If the required notice under this paragraph is not provided to the state agency, all parties to the claim are deemed to have failed to provide the required notice. A party to a claim includes the injured person or the person's legal representative, the plaintiff, the defendants, or persons alleged to be responsible for compensating the injured person or plaintiff, and any other party to the cause of action or claim, regardless of whether the party knows the state agency has a potential or actual lien claim.

Notice given to the local agency is not sufficient to meet the requirements of paragraphs (b) and (c).

Subd. 5. Costs deducted. Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has filed its lien, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of medical assistance, paid to or on behalf of the person as a result of the injury must be deducted next, and paid to the state agency. The rest must be paid to the medical assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and other collection costs.

CREDIT(S)

1998 Main Volume

Laws 1975, c. 247, § 6. Amended by Laws 1976, c. 236, § 2; Laws 1986, c. 444; Laws 1986, 1st Sp., c. 3, art. 1, § 82; Laws 1987, c. 370, art. 2, § § 5 to 8; Laws 1988, c. 689, art. 2, § 143; Laws 1993, 1st Sp., c. 1, art. 5, § 29; Laws 1995, c. 207, art. 6, § 26; Laws 1997, c. 217, art. 2, § § 5 to 7.

2002 Electronic Update

Amended by Laws 1999, c. 245, art. 4, § § 28 to 30.

MN ST § 256B.056
M.S.A. § 256B.056

This document has been updated. Use KEYCITE.

MINNESOTA STATUTES ANNOTATED PUBLIC WELFARE AND RELATED ACTIVITIES CHAPTER 256B. MEDICAL ASSISTANCE FOR NEEDY PERSONS

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Current through End of 2001 1st Sp. Sess.

256B.056. Eligibility; residency; resources; income

Subdivision 1. Residency. To be eligible for medical assistance, a person must reside in Minnesota, or, if absent from the state, be deemed to be a resident of Minnesota in accordance with the rules of the state agency.

Subd. 1a. Income and assets generally. Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used. Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year. Effective upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent

order for child support, and social security payments are not counted as income. For families and children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193, [FN1] shall be used, except that effective July 1, 2002, the $90 and $30 and one-third earned income disregards shall not apply and the disregard specified in subdivision 1c shall apply. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Subd. 1b. Aged, blind, and disabled income methodology. The $20 general income disregard allowed under the supplemental security income program is included in the standard and shall not be allowed as a deduction from income for a person eligible under section 256B.055, subdivisions 7, 7a, and 12.

<Text of subd. 1c effective July 1, 2002.>

Subd. 1c. Families with children income methodology. (a) For children ages one to five whose eligibility is determined under section 256B.057, subdivision 2, 21 percent of countable earned income shall be disregarded for up to four months.

(b) For families with children whose eligibility is determined using the standard specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable earned income shall be disregarded for up to four months.

(c) If the disregard has been applied to the wage earner's income for four months, the disregard shall not be applied again until the wage earner's income has not been

considered in determining medical assistance eligibility for 12 consecutive months.

Subd. 2. Homestead; exclusion for institutionalized persons. The homestead shall be excluded for the first six calendar months of a person's stay in a long-term care facility and shall continue to be excluded for as long as the recipient can be reasonably expected to return to the homestead. For purposes of this subdivision, "reasonably expected to return to the homestead" means the recipient's attending physician has certified that the expectation is reasonable, and the recipient can show that the cost of care upon returning home will be met through medical assistance or other sources. The homestead shall continue to be excluded for persons residing in a long-term care facility if it is used as a primary residence by one of the following individuals:

(a) the spouse;

(b) a child under age 21;

(c) a child of any age who is blind or permanently and totally disabled as defined in the supplemental security income program;

(d) a sibling who has equity interest in the home and who resided in the home for at least one year immediately before the date of the person's admission to the facility; or

(e) a child of any age, or, subject to federal approval, a grandchild of any age, who resided in the home for at least two years immediately before the date of the person's admission to the facility, and who provided care to the person that permitted the person to reside at home rather than in an institution.

Subd. 3. Asset limitations for elderly and disabled individuals. To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(a) Household goods and personal effects are not considered.

(b) Capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered.

(c) Motor vehicles are excluded to the same extent excluded by the supplemental security income program.

(d) Assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program.

(e) Effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of

ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (b).

Subd. 3a. Repealed by Laws 1992, c. 513, art. 7, § 135.

Subd. 3b. Treatment of trusts. (a) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with mental retardation living in an intermediate care facility for persons with mental retardation; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in Sullivan v. Zebley, 110 S.Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

(b) Trusts established after August 10, 1993, are treated according to section 13611 (b) of the Omnibus Budget Reconciliation Act of 1993 (OBRA), Public Law Number 103-66. [FN2]

<Text of subd. 3c effective July 1, 2002.>

Subd. 3c. Asset limitations for families and children. A household of two or more persons must not own more than $30,000 in total net assets, and a household of one person must not own more than $15,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business up to $200,000 are not considered;

(3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;

(4) one burial plot and all other burial expenses equal to the supplemental security income program asset limit are not considered for each individual;

(5) court-ordered settlements up to $10,000 are not considered;

(6) individual retirement accounts and funds are not considered; and

(7) assets owned by children are not considered.

Subd. 4. Income. (a) To be eligible for medical assistance, a person eligible under section 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal

poverty guidelines. Effective January 1, 2000, and each successive January, recipients of supplemental security income may have an income up to the supplemental security income standard in effect on that date.

(b) To be eligible for medical assistance, families and children may have an income up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16, 1996, shall be increased by three percent.

(c) Effective July 1, 2002, to be eligible for medical assistance, families and children may have an income up to 100 percent of the federal poverty guidelines for the family size.

(d) In computing income to determine eligibility of persons under paragraphs (a) to (c) who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94-566, section 503; [FN3] 99-272; [FN4] and 99-509. Veterans aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.

Subd. 4a. Asset verification. For purposes of verification, the value of a life estate shall be considered not salable unless the owner of the remainder interest intends to purchase the life estate, or the owner of the life estate and the owner of the remainder sell the entire property.

Subd. 4b. Income verification. The local agency shall not require a monthly income verification form for a recipient who is a resident of a long-term care facility and who has monthly earned income of $80 or less. The commissioner or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy

between reported income and electronically verified income, an individual may be required to submit additional verification.

Subd. 5. Excess income. A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 5c. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the 20th of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before the 20th of the month in order to be eligible for this option in the following month.

Subd. 5a. Individuals on fixed or excluded income. Recipients of medical assistance who receive only fixed unearned or excluded income, when that income is excluded from consideration as income or unvarying in amount and timing of receipt throughout the year, shall report and verify their income annually.

Subd. 5b. Individuals with low income. Recipients of medical assistance not residing in a long-term care facility. who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income on a semiannual basis.

Subd. 5c. Excess income standard. (a) The excess income standard for families with children is the standard specified in subdivision 4.

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years is 70 percent of the federal poverty guidelines for the family size. Effective July 1, 2002, the excess income standard for this paragraph shall equal 75 percent of the federal poverty guidelines.

Subd. 6. Assignment of benefits. To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person or the person's spouse from any third person liable for the costs of medical care for the person, the spouse, and children. The state agency shall require from any applicant or recipient of medical assistance the assignment of any rights to medical support and third party payments. Persons must cooperate with the state in establishing paternity and obtaining third party payments. By signing an application for medical assistance, a person assigns to the department of human services all rights.the person may have to medical support or payments for medical expenses from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date

of application if the applicant is determined eligible for and receives medical assistance benefits. The application must contain a statement explaining this assignment. Any assignment shall not be effective as to benefits paid or provided under automobile accident coverage and private health care coverage prior to notification of the assignment by the person or organization providing the benefits.

Subd. 7. Period of eligibility. Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. A redetermination of eligibility must occur every 12 months.

Subd. 8. Cooperation. To be eligible for medical assistance, applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payers and assist the state in obtaining third party payments, unless good cause for noncooperation is determined according to Code of Federal Regulations, title 42, part 433.147. "Cooperation" includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. Cooperation also includes providing information about a group health plan for which the person may be eligible and if the plan is determined cost-effective by the state agency and premiums are paid by the local agency or there is no cost to the recipient, they must enroll or remain enrolled with the group. For purposes of this subdivision, coverage provided by the Minnesota comprehensive health association under chapter 62E shall not be considered group health plan coverage or cost-effective by the state and local agency. Cost-effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to section 256B. 19.

CREDIT(S)

1998 Main Volume

Amended by Laws 1989, c. 282, art. 3, § 45; Laws 1989, c. 282, art. 3, § 46, eff. July 1,1990; Laws 1989, c, 282, art. 3, § 47; Laws 1989, c. 332, § 1, eff. May 31, 1989; Laws 1990, c. 568, art. 3, § § 28 to 32; Laws 1992, c. 513, art. 7, § § 34 to 38; Laws 1993, c. 339, § 13; Laws 1993, 1st Sp., c. 1, art. 5, § 31; Laws 1993, 1st Sp., c. 1, art. 6, § 25; Laws 1995, c. 207, art. 6, § § 28, 29; Laws 1995, c. 248, art. 17, § § 1 to 4, eff. Aug. 1, 1995; Laws 1996, c. 451, art. 2, § § 8, 9; Laws 1997, c. 85, art. 3, § § 13 to 15; Laws 1997, c. 203, art. 4, § § 20, 21; Laws 1997, c. 225, art. 6, § 4, eff. June 3, 1997.

2002 Electronic Update

Amended by Laws 1998, c. 407, art. 4, § § 15, 16; Laws 1999, c. 245, art. 4, § 32; Laws 2001, c. 203, § § 5, 6; . Laws 2001, 1st Sp., c. 9, art. 2, § § 16, 17, eff. July 1, 2001; Laws 2001, 1st Sp., c. 9, art. 2, § 18, eff. July 1, 2002; Laws 2001, 1st Sp., c. 9, art. 2, § 19; Laws 2001, 1st Sp., c. 9, art. 2, § 20, eff. July 1, 2002; Laws 2001, 1st Sp., c. 9, art. 2, § 21, eff. July 1, 2001; Laws 2001, 1st Sp., c. 9, art. 2, § 22; Laws 2001, 1st Sp., c. 9, art. 2, § § 23, 24, eff. July 1, 2001.

[FN1] 42 U.S.C.A. § 601 et seq.

[FN2] 42 U.S.C.A. § 1396p.

[FN3] 42 U.S.C.A. § 1396a, note.

[FN4] 29 U.S.C.A. § 1161 et seq. and 42 U.S.C.A. § 300bb-1 et seq.

HISTORICAL AND STATUTORY NOTES

1999 Legislation

Laws 1999, c. 245, art. 10, § 10, par. (b), effective May 26, 1999, repealed Laws 1997, c. 225, art. 6, § 8, which provided in part for the expiration of the amendment of subd. 8 by Laws 1997, c. 225, art. 6, § 4, effective June 30,

* * *

MN ST § 256B.37
M.S.A. § 256B.37

This document has been updated. Use KEYCITE.

MINNESOTA STATUTES ANNOTATED PUBLIC WELFARE AND RELATED ACTIVITIES CHAPTER 256B. MEDICAL ASSISTANCE FOR NEEDY PERSONS QUALITY ASSURANCE

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Current through End of 2001 1st Sp. Sess.

256B.37. Private insurance policies, causes of action

Subdivision 1. Subrogation. Upon furnishing medical assistance to any person who has private accident or health care coverage, or receives or has a right to receive health or medical care from any type of organization or entity, or has a cause of action arising out of an occurrence that necessitated the payment of medical assistance, the state agency or the state agency's agent shall be subrogated, to the extent of the cost of medical care furnished, to any rights the person may have under the terms of the coverage, or against the organization or entity providing or liable to provide health or medical care, or under the cause of action.

The right of subrogation created in this section includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

Subd. 2. Civil action for recovery. To recover under this section, the attorney general may institute or join a civil

action to enforce the subrogation rights of the commissioner established under this section.

Any prepaid health plan providing services under sections 256B.69, 256D.03, subdivision 4, paragraph (d), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county-based purchasing entity providing services under section 256B.692 may retain legal representation to enforce the subrogation rights created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

Subd. 3. Notice. The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the cost of medical care when the state agency has paid or become liable for the cost of care. Notice must be given as follows:

(a) Applicants for medical assistance shall notify the state or local agency of any possible claims when they submit the application. Recipients of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation

claim before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the local agency is not sufficient to meet the requirements of paragraphs (b) and (c).

Subd. 4. Recovery. Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of medical assistance paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency. The rest must be paid to the medical assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and collection costs.

Subd. 5. Private benefits to be used first. Private accident and health care coverage including Medicare for medical services is primary coverage and must be exhausted before medical assistance is paid for medical services including home health care, personal care assistant services, hospice, or services covered under a Health Care Financing Administration (HCFA) waiver. When a person who is otherwise eligible for medical assistance has private accident or health care coverage, including Medicare or a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent.

Subd. 5a. Supplemental payment by medical assistance. Medical assistance payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than

charges as payment in full. Payment for patients that are simultaneously covered by medical assistance and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third party payment amount; or

(3) the medical assistance rate minus the third party payment amount. A negative difference will not be implemented.

Subd. 6. Parent's or obligee's health plan. When a parent or a person with an obligation of support has enrolled in a prepaid health care plan under section 518.171, subdivision 1, the commissioner of human services shall limit the recipient of medical assistance to the benefits payable under that prepaid health care plan to the extent that services available under medical assistance are also available under the prepaid health care plan.

CREDIT(S)

1998 Main Volume

Laws 1975, c. 247, § 7. Amended by Laws 1987, c. 370, art. 2, § § 9 to 14; Laws 1987, c. 403, art. 3, § 26. Amended by Laws 1993, 1st Sp., c. 1, art. 5, § § 87 to 89; Laws 1996, c. 451, art. 2, § 32; Laws 1997, c. 217, art. 2, § 8.

2002 Electronic Update

Amended by Laws 1999, c. 245, art. 4, § § 66, 68.

HISTORICAL AND STATUTORY NOTES

**42 P.L. 99-272, COMPREHENSIVE OMNIBUS BUDGET RECONCILIATION ACT OF 1986

DATES OF CONSIDERATION AND PASSAGE

House: October 24, 31, December 5, 19, 20, 1985; March 6, 18, 20, 1986

Senate: November 14, December 19, 20, 1985; March 14, 18, 1986

House Report (Ways and Means Committee) No. 99-241(I), July 31, 1985 [To accompany H.R. 3128]

House Report (Education and Labor Committee) No. 99-241(II), Sept. 11, 1985 [To accompany H.R. 3128]

House Report (Judiciary Committee) No. 99-241 (III), Sept. 11, 1985 [To accompany H.R. 3128]

Senate Report Budget Committee) No. 99-146, Oct. 2, 1985 [To accompany S. 1730]

House Conference Report No. 99-453, Dec. 19, 1985 [To accompany H.R. 3128] (rejected by the House on Dec. 19, 1985)

Cong. Record Vol. 131(1985)

Cong. Record Vol. 132 (1986)

Related Reports:

House Report (Budget Committee) No. 99-300, Oct. 3, 1985 [To accompany H.R. 3500]

The House bill was passed in lieu of the Senate bill after amending its language to contain much of the text of the Senate bill. The Senate Report, the House Report, and a Related Report are set out.

(CONSULT NOTE FOLLOWING TEXT FOR INFORMATION ABOUT OMITTED MATERIAL. EACH COMMITTEE REPORT IS A SEPARATE DOCUMENT ON WESTLAW.)

SENATE REPORT NO. 99-146
October 2, 1985

*1 The Committee on the Budget, to which were submitted recommendations pursuant to section 2 of the First Concurrent Resolution on the Budget for Fiscal Year 1986 (S. Con. Res. 32, Ninety-ninth Congress), having considered the same, reports favorably thereon and recommends that the bill embodying those recommendations do pass.

**43 *3 VIEWS OF THE COMMITTEE ON THE BUDGET

Reconci'iation is an important tool to restrain Federal spending. It is authorized and described in Title III of the Congressional Budget and Impoundment Control Act of 1974 (Pub. L. 93-344). The reconciliation procedure allows Congress to consider changes in spending and revenues within the purview of several committees in a single bill, while reserving to those committees the power to determine what changes will be made in laws within their respective jurisdiction.

On August 1, 1985, Congress adopted S. Con. Res. 32, the First Concurrent Resolution on the Budget for Fiscal Year 1986. That resolution mandated major reductions in the staggering budget deficits now facing the United States. Revenue and spending targets for the fiscal years 1986 through 1988 contained in the resolution will lower deficits over the next 3 years by $276.2 billion.

In order to realize the fiscal policy set forth in S. Con. Res. 32, Congress included in that resolution instructions to 11 Senate committees and 14 House committees to recommend changes in laws in their jurisdiction which would reduce Federal spending by $20.1 billion in budget authority and $67.1 in outlays during FY 1986 through FY 1988. In addition, the Senate Finance and House Ways and Means Committees

were instructed to recommend revenue increases totaling $8.4 billion during that 3-year period. ...

* * *

Effective date.--Enactment.

4. Extension of Texas Long-Term Care Waiver

Current law.--Section 1115 of the Social Security Act provides the Secretary of HHS general authority to conduct experiments and demonstrations under Medicaid and to waive program requirements in conducting these demonstrations. Under this authority, the Secretary has approved a waiver for the demonstration project, Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged, for the period January 1980 throughout December 1985.

Explanation of provision.--The provision would require the Secretary to extend through December 31, 1988, approval of the waiver for the demonstration project, Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged and to continue the approval on the same terms and conditions as applied to the project as of the date of enactment of this Act.

Effective date.--October 1, 1985.

5. Enhance Third-Party Liability Collections

Current law.--Medicaid is intended to be the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program.

Explanation of provision.--The provision would require the Secretary to issue regulations so that the States:

a. collect sufficient information to identify third party liabilities,

b. computer match information about the beneficiary with other data bases, as specified by the Secretary, and

c. use that information to pursue collections according to a plan approved by the Secretary of Health and Human Services.

The regulations would also provide that the States be financially penalized for not collecting the required information or not following through with the agreed-on collection plan. The provision would also make disclosure of third party liability a condition of eligibility for Medicaid. The provision clarifies the responsibility of Medicaid recipients for copayments and deductibles when third **280 *313 parties are liable for payments on their behalf. The provision would also clarify that Medicaid is the payer of last resort with respect to self-insured plans.

Effective date.--October 1, 1985.

6. Optional Targeted Case Management Services

Current law.—'Case management' is commonly understood to be a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization. Under current Medicaid law, case management is not included among the list of medical services which may be covered under a State's Medicaid plan. However, States may include case management services under freedom-of-choice and home and community-based services waivers authorized under section 1915(b) and 1915(c) respectively. In addition, States may receive administrative funds under their Medicaid plans for certain case management activities (for example, preadmission screening) when offered to all Medicaid recipients in all areas of the State.

Explanation of provision.--The provision would modify current law to include case management among the list of medical services which may be covered under a State's Medicaid plan and would allow States to target case

management services to specific groups and/or specific areas within the State without obtaining a home and community based services waiver. The intent is to allow case management to be provided as an additional service. It is not the Committee's intent that the States use case management solely to reduce program costs. It is the committee's intent that the States may target any Medicaid group, including the nonelderly, under this provision.

Effective date.--October 1, 1985.

01-01 GENERAL FINANCIAL ELIGIBILITY REQUIREMENTS AND OPTIONS 3810

3810. MEDICAID ESTATE RECOVERIES

Under the estate recoveries provisions in §1917(b) of the Act, you must recover certain Medicaid benefits correctly paid on behalf of an individual. The following instructions explain the rules under which you must recover from an individual's estate Medicaid benefits correctly paid and incorrectly paid.

A. Adjustment and Recovery.--You must seek adjustment or recovery of medical assistance correctly paid on behalf of an individual under your State plan as follows.

1. Permanently Institutionalized Individuals.-- All States that impose the Tax Equity Fiscal Responsibility Act (TEFRA) liens are required to determine if an individual is permanently institutionalized. TEFRA liens are pre-death liens that are placed upon the home of living beneficiaries who have been determined (after notice and opportunity for a hearing) to be permanently institutionalized. These liens must follow rules set out in the TEFRA of 1982. In the case of permanently institutionalized individuals who the State determines cannot reasonably be expected to be discharged and return home, including individuals of any age, you must seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien, at a minimum, of amounts spent by Medicaid on the person's behalf for services provided in a nursing

facility, ICF/MR, or other medical institution. The date on which you determine the individual to be permanently institutionalized does not affect which expenditures you must or may recover from the individual or his/her estate. If you elect to recover all medical assistance, it would include assistance furnished prior to the time you determined the individual to be permanently institutionalized. If you only elect to recover for expenditures for institutional services, you must recover for all institutional services furnished to the individual, regardless of whether they were furnished during the current stay in the facility. Your State plan must reflect the medical assistance subject to recovery. Recoveries must be made from the individual's estate (after death) or from the proceeds of the sale of the property on which a lien has been placed.

Permanently institutionalized individuals are persons of any age who are inpatients in a nursing facility, ICF/MR, or other medical institution as defined in 42 CFR 435.1009, and who must, as a condition of receiving services in the institution under your State plan, apply their income to the cost of care, as provided in 42 CFR 435.725, 42 CFR 435.733, 42 CFR 435.832, and 42 CFR 436.832.

If you use TEFRA liens, you must specify in your State plan the process by which you will determine that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home, the notice to be given the individual, the process by which the individual will be given the opportunity for a hearing, the hearing procedures, and by whom and on what basis the determination that the individual cannot reasonably be expected to be discharged from the institution will be made. States are not required to use the Supplemental Security Income intent to return home rule for purposes of determining whether an individual is permanently

institutionalized for purposes of estate recovery. This rule applies only to eligibility determinations.

2. Individuals Age 55 or Older.--You must seek adjustment or recovery from the estate of an individual who was age 55 or older when that person received medical assistance. You must recover up to the total amount spent by Medicaid on the person's behalf, for spending on nursing facility services, (which includes skilled nursing facility and intermediate care facility for the mentally retarded services), home and community based services, as defined in §§1915(c) and (d), 1929, and 1930 of the Act, and related hospital and prescription drug services. Related hospital and prescription drug services are any hospital care or prescription services provided to an individual while receiving nursing facility services and home and community-based services. At your option, you may also recover additional amounts up to the total amount spent on the individual's behalf for medical assistance for any or all other items or services under your State plan. List these other items and services in your State plan. Recovery is limited to medical assistance for services received at age 55 or thereafter.
3. Dual Eligibles.--Dual eligibles are individuals who are entitled to Medicare Hospital Insurance under Part A and/or Supplementary Medical Insurance under Part B and are eligible for some form of Medicaid benefit. Depending on the eligibility category, Medicaid may provide benefits limited to payment of Medicare cost-sharing expenses (premiums, deductibles, and coinsurance) or only Medicare Part B premiums, and for some groups full Medicaid benefits. (See SMM sections 3489-3492 for the eligibility criteria and benefits available.)

a. Mandatory Estate Recovery.--You must recover from the estate of the following dual eligibles who receive full Medicaid benefits in addition to Medicare: (1) Qualified Medicare Beneficiaries with full Medicaid benefits (QMB Plus), (2) Specified Low-Income Medicare Beneficiaries with full Medicaid benefits (SLMB Plus), and (3) Medicaid Only Dual Eligibles (non QMB, SLMB, or QDWI). You must recover from the individual's estate for the Medicaid mandatory services (nursing facility, home and community-based services, and related prescription and hospital services) as well as for optional medical assistance recovery specified in the State plan for the groups described. In addition, you must include in your claim against the estate, medical assistance amounts expended for Medicare cost-sharing and/or Medicare premiums.

b. Optional Estate Recovery.--Low income Medicare beneficiaries, who are receiving assistance from Medicaid agencies in the payment of their Medicare copayments and/or deductibles, can be exempt from Medicaid estate recovery, at State option, because they are not entitled to, or receiving, any Medicaid mandatory services which are subject to recovery.

4. Individuals With Long Term Care Insurance Policies.

a. Adjustment or Recovery Required.--Except as provided in §3810.A.4.b, you must seek adjustment or recovery from the individual's estate for all Medicaid costs for nursing facility and other long term care services if: (1) assets or resources are disregarded to the extent of payments made under a long term care insurance policy; or (2) assets or resources are disregarded

because the individual received (or is entitled to receive) benefits under a long term care insurance policy.

b. Assets or Resources Disregarded/Not Disregarded.--If you had an approved State plan, as of May 14, 1993, (California, Connecticut, Indiana, Iowa, and New York) which provided for the disregard of assets or resources in determining eligibility for medical assistance either to the extent that payments are made under a long term care insurance policy, or because an individual has received or is entitled to receive benefits under such a policy, you are not required to seek adjustment or recovery from the individual's estate for Medicaid costs for nursing facility and other Medicaid long term care expenses. While HCFA cannot compel you to recover any amounts from the estates of these individuals, you are free to do so if consistent with the terms of your State plan.

5. Adjustment or Recovery Limitations.--Adjustment or recovery can only be made after the death of the individual's surviving spouse, if any, and only at a time when the individual has no surviving child under age 21, or a blind or disabled child as defined in §1614 of the Act. For Guam, Puerto Rico, and the Virgin Islands, any surviving child's blindness or permanent or total disability would be determined under the definitions found in the State plan program for providing assistance to the blind or permanently and totally disabled. If a lien is placed on an individual's home, adjustment or recovery can only be made when: (1) there is no sibling of the individual residing in the home, who has resided there for at least one year immediately before the date of the individual's admission to the institution, and has resided there on a continuous basis since

that time; and (2) there is no son or daughter of the individual residing in the home, who has resided there for at least two years immediately before the date of the individual's admission to the institution, has resided there on a continuous basis since that time, and can establish to the agency's satisfaction that he/she has been providing care which permitted the individual to reside at home rather than in an institution.

6. Estate Recovery and Managed Care.--When a Medicaid beneficiary, permanently institutionalized, or age 55 or older, is enrolled (either voluntarily or mandatorily) in a managed care organization and services are provided by the managed care organization that are included under the State's plan for estate recovery, you must seek adjustment or recovery from the individual's estate for the premium payments in your claim against the estate. When the beneficiary enrolls in the managed care organization, you must provide a separate notice to the beneficiary that explains that the premium payments made to the managed care organization are included either in whole or in part in the claim against the estate.
    - If you have elected in your State plan amendment to recover for all Medicaid services, then you must recover from the individual's estate the total capitation rate for the period the beneficiary was enrolled in the managed care organization.
    - If you have elected in your State plan amendment to recover for some services covered under the State plan, but not all services, then you must recover from the individual's estate that portion of the capitation payment that is attributable to the recoverable services, based on the most

appropriate actuarial analysis determined by the State.

7. American Indians and Alaska Natives.--The Federal government has a unique trust responsibility for American Indian (AI) Tribes and Alaska Native (AN) Villages and their members. Section 1917(b)(3) of the Social Security Act gives the Secretary authority to establish standards for hardship. This includes exemptions from estate recovery for certain assets and resources.
   a. American Indians and Alaska Natives: Income, Resources and Property Exempt from Medicaid Estate Recovery.--The following AI/AN income, resources, and property are exempt from Medicaid estate recovery:
      1. Certain AI/AN income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
      2. Ownership interest in trust or non-trust property, including real property and improvements:
         a. Located on a reservation (any federally recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
         b. For any federally-recognized Tribe not described in (a), located within the most

recent boundaries of a prior Federal reservation.

c. Protection of non-trust property described in (a) and (b) is limited to circumstances when it passes from an Indian (as defined in section 4 of the Indian Health Care Improvement Act) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a Tribe and non-Indians, such as spouses and stepchildren, that their culture would nevertheless protect as family members; to a Tribe or Tribal organization; and/or to one or more Indians;

3. Income left as a remainder in an estate derived from property protected in 2 above, that was either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.
4. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of Federally-protected rights, and income either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and
5. Ownership interests in or usage rights to items not covered by 1-4 above that have unique religious, spiritual, traditional, and/or cultural significance or rights that support

subsistence or a traditional life style according to applicable Tribal law or custom.

b. American Indians and Alaska Natives Income, Resources and Property Not Exempt from Medicaid Estate Recovery.--You may recover the following income, resources and property from the estates of American Indians and Alaska Natives;

1. Ownership interests in assets and property, both real and personal, that are not described in 7.a, items 1-5 above.
2. Any income and assets left as a remainder in an estate that do not derive from protected property or sources in 7.a, items 1-5.

8. Reparation Payments to Individuals.--Government reparation payments to special populations are exempt from Medicaid estate recovery.

B. Definition of Estate.--Specify in your State plan the definition of estate that will apply.

1. Probate Definition.--At a minimum, you must include all real and personal property and other assets included within the individual's estate as provided in your State probate law.
2. Optional Definition.--In addition to property and assets under the probate definition, you may include any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest). This includes assets conveyed to a survivor, heir, or assign of the deceased through joint tenancy, tenancy in common survivorship, life estate, living trust, or other arrangement.
3. Special Rule for Individuals With Long Term Care Insurance.--In the case of individuals described in §3810.A.4.(a), you must use the definition of estate as described in subsection B.2.

4. Annuities.--You may collect against an annuity that was the property of the deceased Medicaid beneficiary if you use State probate law to define estate, and the law includes annuities, or, if you use the expanded definition of estate found at §3810.B.2. When using the expanded definition of estate, an annuity is considered an "other arrangement." If you use the expanded definition of estate, this provision is effective for deaths or estates that are opened 90 days after the publication of this manual provision and after the State meets applicable State and Federal law for appropriate notice and due process.

C. Undue Hardship.--Where estate recovery would work an undue hardship, adjustment or recovery is waived. Establish procedures and standards for waiving estate recoveries when they would cause undue hardship. You may limit the waiver to the period during which the undue hardship circumstances continue to exist. Describe your policy in your State plan. You have flexibility in implementing an undue hardship provision. However, your undue hardship waiver protection does not apply to individuals with long term care insurance policies who became Medicaid eligible by virtue of disregarding assets because of payments made by a long term care insurance policy or because of entitlement to receive benefits under a long term care insurance policy. California, Connecticut, Indiana, Iowa, and New York must apply their undue hardship rules to all individuals, including those eligible for Medicaid by virtue of State plan provisions related to the purchase of a long term care insurance policy.

1. Undue Hardship Defined.--The legislative history of §1917 of the Act states that the Secretary should provide for special consideration of cases in which the estate subject to recovery is: (1) the sole income-

producing asset of survivors (where such income is limited), such as a family farm or other family business; (2) a homestead of modest value; or (3) other compelling circumstances. HCFA suggests that you consider the examples listed above in developing your hardship waiver rules, but does not require you to incorporate these examples once you have considered whether they are appropriate for determining the existence of an undue hardship.

In considering your criteria, you may conclude that an undue hardship does not exist if the individual created the hardship by resorting to estate planning methods under which the individual illegally divested assets in order to avoid estate recovery.

In defining a homestead of modest value, the methodology the State uses to set a threshold level for the market value of a "homestead of modest value" cannot be set so high as to negate the intent of the estate recovery program. For purposes of this provision, a homestead of "modest value" can be defined as fifty percent (50%) or less of the average price of homes in the county where the homestead is located, as of the date of the beneficiary's death. Describe your methodology for determining a home of modest value in your State plan.

D. Collection Procedures.--You must adopt procedures under which individuals who will be affected by recovery of amounts of medical assistance will have the right to apply for an undue hardship waiver. These procedures must, at a minimum, provide for advance notice of any proposed recovery. They must also specify the method for applying for a waiver, the hearing and appeal rights, and the time frames involved. You should specify the procedures for collection, which must be reasonable. In the situation where recovery is not waived because of undue hardship and heirs of the estate from which recovery is sought wish to satisfy your recovery claim without a

non-liquid asset subject to recovery, you may establish a reasonable payment schedule subject to reasonable interest. You may also undertake partial recovery to avoid an undue hardship situation.

E. Adjustment or Recovery Not Cost Effective.--You may waive adjustment or recovery in cases in which it is not cost effective for you to recover from an individual's estate. The individual does not need to assert undue hardship. You may determine that an undue hardship exists when it would not be cost effective to recover the assistance paid. You may adopt your own reasonable definition of cost effective. However, any methodology you use for determining cost-effectiveness must be included in your State plan. If you made individuals eligible for Medicaid because of a long term care insurance, you are restricted from using this waiver authority unless you had as of May 14, 1993, an approved State plan which provided for long term care insurance-related disregards from income. In that event, you can use the undue hardship exception as a basis for applying a cost effectiveness test to individuals who became eligible based upon long term care insurance-related disregards.

F. Placement of TEFRA Liens.--You are not required to use TEFRA liens in §1917(a) of the Act. Section 13612 of OBRA 1993 did not mandate the use of TEFRA liens. The TEFRA liens allow you to place liens on certain types of property and recover specific types of payments as described in subsection F.1. and F.2. You may use liens as a mechanism/tool to recover medical assistance incorrectly paid as indicated in F.1, or correctly paid on behalf of certain permanently institutionalized individuals, as indicated in subsection F.2.

1. Incorrect Payments.--You may place a lien against an individual's property both personal and real, before his or her death because of Medicaid claims

paid or to be paid on behalf of that individual if a court determines that benefits were incorrectly paid for that individual.

2. Correct Payments.--You may place a TEFRA lien against the real property of an individual of any age before his or her death because of Medicaid claims paid or to be paid for that individual when: (1) he/she is an inpatient of a medical institution and must, as a condition of receiving services in the institution under State plan, apply his/her income to the cost of care (as provided in 42 CFR 435.725, 42 CFR 435.733, 42 CFR 435.832, and 42 CFR 436.832), and (2) the agency determines that the person cannot reasonably by expected to return home as specified in §3810.A.1. The State's authority to place a lien after the individual's death is not restricted by the TEFRA lien provisions.
3. Restriction on Placement of TEFRA Liens.--You may not place a TEFRA lien, as indicated in subsection F.2., on an individual's home if any of the following individuals are lawfully residing in the home: (1) the spouse, (2) the individual's child who is under age 21 or blind or disabled, as defined in §1614 of the Act, in States (or blind or permanently and totally disabled in Guam, Puerto Rico, and the Virgin Islands), or (3) the individual's sibling (who has an equity interest in the home), and who was residing in the individual's home for at least one year immediately before the date the individual was admitted to the medical institution.
4. Termination of Liens.--You must dissolve any lien imposed as provided in subsection F.2 on an individual's real property when that individual is discharged from the medical institution and returns home.

G. Notice.--

1. General Notice.--You should provide notice to individuals at the time of application for Medicaid that explains the estate recovery program in your State.
2. Recovery or Adjustment Notice.--You should give a specific notice to individuals affected by the proposed recovery whenever you seek adjustment or recovery. The notice should be served on the executor or legally authorized representative of the individual's estate, or, if these are not known to the State, other survivors or heirs. The executor or legally authorized representative should be required to notify individuals who would be affected by the proposed recovery. In the situation where there is no executor or legally authorized representative, the State should notify the family or the heirs. The notice should include, at a minimum, the action the State intends to take, reason for the action, individual's right to a hearing (42 CFR Subpart E), method by which he/she may obtain a hearing, procedures for applying for a hardship waiver, and the amount to be recovered. An administrative hearing is not required if State law provides for court review as the next appellate step.

H. Effective Date of New Provision.--Section 13612 of OBRA 1993 does not apply to individuals who died before October 1, 1993. This section applies to Medicaid payments beginning on or after October 1, 1993.

I. Effective Date - States With Estate Recovery Programs in Effect Prior to October 1, 1993.-- If you had an estate recovery program approved under your State plan and in operation prior to October 1, 1993, for individuals of any age who are determined permanently institutionalized prior to October 1, 1993, you may recover from the estate or upon sale of the property subject to a lien for all services correctly paid before

October 1, 1993. You may also recover for services paid for before October 1, 1993, from the estate of an individual age 65 or older when that person received medical assistance. Recovery for these services is in accord with the features of your approved plan in effect prior to October 1, 1993.

02-83 GENERAL FINANCIAL ELIGIBILITY REQUIREMENTS AND OPTIONS 3812

3812 TREATMENT OF CONTRIBUTIONS FROM RELATIVES TO MEDICAID APPLICANTS OR RECIPIENTS

Section 1902(a)(17) of the Social Security Act (the Act) provides that a State plan must include reasonable standards for determining Medicaid eligibility that do not take into account the financial responsibility of any individual for any applicant or recipient of Medicaid unless the applicant or recipient is the individual's spouse, or child under age 21, or a child over age 21 who is blind or disabled. Under Medicaid regulations (42 CFR 435.602 and 436.602), States may consider only the income and resources of spouses as available to each other; and income and resources of parents as available to children under age 21, or children over 21 if they are blind or disabled. The income and resources of any other relative are not considered available to the individual. While the regulations do not deal with contributions actually made by relatives, any voluntary contributions actually made by relatives or friends are to be taken into account by the State in determining Medicaid eligibility. It should be noted, however, that this policy is not related to, nor does it affect, rules on deeming of income for purposes of determining eligibility.

The law and regulations permit States to require adult family members to support adult relatives without violating the Medicaid statute by the use of a statute of general applicability. Such contribution requirements are permissible

as a State option. There are two legally supportable interpretations of section 1902(a)(17)(D) of the Act upon which to base this policy. First, if support is required under a State statute of general applicability, and not under a State plan requirement applicable only to Medicaid recipients, the statute would not violate the requirements of 1902(a)(17)(D) of the Act that a State plan cannot take into account the financial responsibility of relatives other than parents or spouses. Second, section 1902(a)(17)(D) of the Act can be interpreted as prohibiting only the "deeming" of income (that is, the assumption that income is available to the Medicaid applicant or recipient whether or not it is actually received), except in limited specified circumstances. Thus, a policy which would permit States to consider only income actually received even though relative contributions are required by a general support statute, would not be in violation of section 1902(a)(17)(D). Furthermore, such a policy is consistent with section 1902(a)(17)(B), which provides for taking into account only such income and resources as are actually available.

Required contributions must be imposed under a State statute of general applicability, and cannot be imposed just as a State plan provision. This means that the law cannot limit provisions requiring contributions from relatives. The State may not assume that these funds are available, nor may a State reduce its payments to Medicaid providers in anticipation of the receipt of a relative's payment. Within these guidelines, the State may determine who is a relative, how much relatives must contribute under the statute of general applicability, and the methods of enforcement. Amounts actually received by an applicant or recipient as a result of a State support statute of general applicability that requires the contribution must be counted as income in determining Medicaid eligibility.

It should be noted that third party liability regulations at 42 CFR 433, subpart D, do not apply to collections pursuant to a statute of general applicability. Third party liability is

expressly limited by 42 CFR 435.602 and 436.602 to spouses and parents, as noted above.

Rev. 2

Supreme Court of the United States

No.
01A864

MINNESOTA,

Petitioner

v.

JOAN MARTIN, GUARDIAN AD LITEM FOR TROY HOFF

ORDER

UPON CONSIDERATION of the application of counsel for the petitioner,

IT IS ORDERED that the execution and enforcement of the judgment of the Supreme Court of Minnesota, case No. C3-00-398, be, and the same is hereby, stayed pending receipt of a response and further order of the undersigned or of the Court.

/s/ Clarence Thomas
Associate Justice of the Supreme
Court of the United States

Dated this 13th
day of May 2002.

Supreme Court of the United States

No.
01A864

MINNESOTA,

Applicant,

v.

JOAN MARTIN, GUARDIAN AD LITEM FOR TROY HOFF, ET AL.

ORDER

UPON FURTHER CONSIDERATION of the application of counsel for the applicant, and the response filed thereto,

IT IS ORDERED that the stay of the execution and enforcement of the judgment heretofore issued by the undersigned on May 13, 2002, is hereby vacated. The application for stay is, in all respects, denied.

/s/ Clarence Thomas
Associate Justice of the Supreme
Court of the United States

Dated this 20th
day of May 2002.

Supreme Court of the United States

No.
01A864

MINNESOTA,

Applicant,

v.

JOAN MARTIN, GUARDIAN AD LITEM FOR TROY HOFF, ET AL.

ORDER

UPON CONSIDERATION of the application of counsel for the applicant to reopen the application,

IT IS ORDERED that the execution and enforcement of the judgment of the Supreme Court of Minnesota, case No. C3-00-398, be, and the same is hereby, stayed pending further order of the undersigned or of the Court.

/s/ Clarence Thomas
Associate Justice of the Supreme
Court of the United States

Dated this 23rd
day of May 2002.

Supreme Court of the United States

No.
01A864

MINNESOTA,

Applicant,

v.

JOAN MARTIN, GUARDIAN AD LITEM FOR TROY HOFF, ET AL.

ORDER

UPON FURTHER CONSIDERATION of the application of counsel for the applicant to reopen the application, and the response filed thereto,

IT IS ORDERED that the stay of the execution and enforcement of the judgment heretofore issued by the undersigned on May 23, 2002, is hereby vacated. The application for stay is, in all respects, denied.

/s/ Clarence Thomas
Associate Justice of the Supreme Court of the United States

Dated this 30th day of May 2002.

Department of Health and Human Services (H.H.S.)
Departmental Appeals Board

Appellate Division

CALIFORNIA DEPARTMENT OF HEALTH SERVICES
Docket No. A-94-114
Control No. A-09-92-00095
Decision No. 1504
January 5, 1995

DECISION

The California Department of Health Services (California or State) appealed a determination by the Health Care Financing Administration (HCFA) disallowing $7,592,786 in federal financial participation (FFP) claimed under title XIX (Medicaid) of the Social Security Act (Act). The disallowance represents the federal share of amounts which HCFA determined California should have collected from third party liability (TPL) settlements and awards received by Medicaid recipients from July 1, 1988 through June 30, 1992. HCFA determined that these amounts should have been credited against California's previous claims for its expenditures on behalf of these recipients.

Under California law, when California provides medical benefits to a Medi-Cal (California's name for Medicaid) recipient because of an injury for which a third party is liable, California is entitled to recover the reasonable value of the benefits from that third party. This case arose because California did not fully recover, from TPL settlements and awards obtained by Medi-Cal recipients, reimbursement for the reasonable value of the Medi-Cal benefits it provided; instead, California allowed recipients to retain at least 50% of

the settlement or award. HCFA determined that, under the Act, HCFA must be fully reimbursed for the federal share before the recipient may receive any money from a TPL settlement or award. HCFA therefore disallowed the federal share of TPL payments that California allowed the recipients to retain.

California appealed this disallowance on the ground that HCFA had no authority under the Act to prohibit states from allowing recipients to retain portions of TPL payments which did not represent payment for medical care. California further argued that its TPL recovery program was highly successful and furthered federal TPL requirements by maximizing TPL recoveries while reducing TPL associated administrative expenses.

Based on our review of the evidence and argument in the record, and the relevant provisions of the Act, we conclude that HCFA's interpretation of the Act is a reasonable construction of its express terms and is supported by the legislative history. Further, California has had notice of HCFA's interpretation of these TPL provisions since 1988. Accordingly, we uphold the disallowance.

Relevant Federal Authority

The Act requires a state to take "all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the [Medicaid] plan . . . ." Section 1902(a)(25)(A). In cases where liability is found to exist after medical assistance is provided, "the State . . . will seek reimbursement for such assistance to the extent of such legal liability." Section 1902(a)(25)(B). A state is not required to seek such reimbursement if "the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery . . . ." Id.

Applicants for Medicaid are required to assign to the state their rights to "payment for medical care from any third party" and to cooperate with the state's pursuit of third party

payment. Section 1912(a). The amount collected under such an assignment--

shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.
Section 1912(b).

Legitimate costs of obtaining the settlement or award, such as attorney's fees, may be deducted prior to reimbursement of the Medicaid program. HCFA's State Medicaid Manual (SMM) § 3907, HCFA Exhibit (Ex.) A.

Relevant California Statutory Authority

Under California law, if California provides Medi-Cal benefits to a recipient because of an injury for which a third party is liable, California is entitled to recover, from that third party, the reasonable value of the benefits it provided. Cal. Welf. & Inst. Code § 14124.71(a).

California has enacted a statutory scheme to effectuate such TPL recoveries from tortfeasors and their insurers. Cal. Welf. & Inst. Code § § 14124.70- 14124.90. Under California's scheme, any settlement, judgment, or award obtained by a recipient is subject to California's claim for reimbursement of the Medi-Cal benefits. Cal. Welf. & Inst. Code § 14123.74. If a representative of a Medi-Cal recipient or the recipient brings an action against a third party who may be liable for an injury which has resulted in Medi-Cal expenditures, he or she must provide notice of the action to California. Cal. Welf. & Inst. Code § 14124.79. This notice enables California to perfect a lien upon any judgment or settlement that the recipient obtains from the third party. Cal. Welf. & Inst. Code § § 14124.76, 14124.77. Further, after payment of the litigation costs and attorney's fees, California's lien is given

priority in the distribution of any judgment or award obtained by the victim. Cal. Welf. & Inst. Code § 14124.74.

Under California's statutory scheme, any recovery by the Medi-Cal recipient is distributed pursuant to one of three alternative methods:

o The 25% method. California Welfare and Institutions Code section 14124.72(d) provides that, where the action is brought by the victim (without California) and the victim incurs a personal liability to pay attorney's fees and costs of litigation, California's claim for reimbursement is limited to the amount of California's Medi-Cal expenditures, less a portion of the costs of litigation and 25% for attorney's fees. [FN1]

o The 50% method. California Welfare and Institutions Code section 14124.78 limits California's claim to not more than one half of the recipient's recovery after deducting for attorney's fees, litigation costs and medical expenses paid for by the recipient relating to the injury. [FN2]

o The waiver method. California Welfare and Institutions Code section 14124.71(b) allows California to waive part or all its claim on the lien and take less than it would be entitled to under the 25% or 50% method if it determines that waiver is appropriate. [FN3]

When California is notified that a settlement or judgment has occurred, California compares the collection obtainable under the 25% and the 50% methods. California collects the lower of the two identified amounts unless a waiver is appropriate under Welfare and Institutions Code section 14124.71(b). If it determines that a waiver is appropriate, California further reduces the amount it could have collected under the 25% or the 50% method.

The Federal Audit

The Office of the Inspector General of Audit Services (OIGOAS) examined State records concerning TPL

recoveries for the period July 1, 1988 through June 30, 1992. A universe of 2,445 cases was defined by identifying all cases with transaction codes indicating that California's TPL collection was calculated pursuant to the 50% method under Welfare and Institutions Code section 14124.78 (transaction code 449) or was reduced pursuant to the waiver method under section 14124.71(b)(2) (transaction code 440). The auditors then reviewed a random sample of 300 cases in the universe to evaluate the amount California actually collected from the TPL settlements and awards.

For each sample case, OIGOAS calculated a Medicaid "net lien" by applying California's 25% method: the total Medicaid expenditures less a percentage for attorney's fees and a pro rata share of costs. It concluded this was the amount California should have sought from the recipient's third party recovery. OIGOAS then determined whether the amount of the settlement was sufficient to compensate the attorney, pay the litigation costs, and reimburse California for the net lien amount. If it was, OIGOAS questioned the federal share of the difference between the net lien amount and the amount California collected. If the settlement amount was not sufficient, OIGOAS questioned the federal share of the difference between the amount of the settlement less actual legal fees and costs and the amount California collected. [FN4]

OIGOAS found that California did not give HCFA full financial credit in 241 of the 300 cases sampled. The majority of the cases (about two-thirds) involved the 50% rule, whereby California limited its recovery to half of the amount remaining after deducting for attorney's fees, litigation costs, and out-of-pocket medical expenses. The waiver rule made up most of the balance of cases. (Miscellaneous errors, chiefly mathematical and clerical, account for the remaining, small fraction of cases.)

OIGOAS projected the results of its sample case findings to the universe of 2,445, cases. By projecting its findings, 0IGOAS determined that, at a minimum, the federal share of

the amount available but not collected by California was $7,592,786. HCFA adopted OIGOAS' audit recommendations and disallowed that amount.

Analysis

California appealed this disallowance on the grounds that HCFA had unreasonably prohibited California from allowing recipients to retain portions of TPL payments which did not represent payment for medical care.

HCFA took the position that the Act requires states to fully reimburse HCFA for the federal share of medical assistance expenditures resulting from the acts of a liable third party before allowing a recipient to receive money from a TPL settlement or award. Thus, according to HCFA, a state must collect from a recipient's TPL recovery, to the maximum extent possible after deducting attorney's fees and litigation costs, the full amount of its Medicaid expenditures and remit the federal share of the expenditures to HCFA. HCFA based its position on three provisions of the Act:

- Section 1912(a)(1)(A), which requires all recipients to execute an assignment of rights "to payment for medical care from any third party;"
- Section 1902 (a)(25)(B), which requires states to seek TPL reimbursement to the extent of a third party's liability;
- Section 1912(b), which provides that any amount a state collects under a recipient's assignment to payment for medical care must be used first to reimburse the Medicaid program for medical assistance payments and that the recipient is entitled only to the remainder.

HCFA's position is directly supported by these provisions of the Act. Recipients, as a condition of eligibility, must assign their rights to payment for medical care. States are then charged with the responsibility of seeking third party recovery pursuant to such assignments. States are further required to seek as much reimbursement as possible, i.e., to the extent of the third party's liability. Finally, when a

recovery is made, the Act sets forth a distribution scheme which requires the Medicaid program to be reimbursed prior to distributing any funds to the recipient. While section 1912(a) refers to assignment only of "payment for medical care," the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first.

HCFA's position is also consistent with the purposes behind Medicaid TPL requirements: to make Medicaid the payor of last resort where there is a liable third party, so as to reduce Medicaid expenditures. In 1985, when Congress amended the Act to strengthen TPL recovery requirements, the accompanying legislative history provided: "Medicaid is intended to be the payor of last resort; that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." Consolidated Omnibus Budget Reconciliation Act of 1985, H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 542 (1985), reprinted in Legislative History of Titles I-XX of the Social Security Act, Vol. XXII, 99th Congress 1985-1986, Part 1. The language clearly indicates that Congress intended for the Medicaid program to be reimbursed from available third party sources to the fullest extent possible.

Moreover, California has had timely notice of HCFA's construction of the statutory provisions relating to TPL payments since June 1988. In Medicaid Regional Memorandum No. 88-10, HCFA expressly addressed the issue of "State lien laws which permit a Medicaid recipient, who initiates pursuit of TPL recovery from a liable third party, to keep a fixed percentage of the recovered amounts before the State (and Federal Government) receives its share of the settlement." In the memorandum, HCFA instructed states that

> [i]n the absence of specific State provisions assuring full reimbursement of the Federal share, the State laws in question would be in conflict with section 1912(b). As a result, the State's actual recovery becomes impermissibly

reduced such that the full Federal share (based on the total net recovery) would not be refunded. The recipient has a right only to the remainder after Medicaid payments are fully reimbursed.
HCFA Ex. C. [FN5]

Since California had notice of HCFA's interpretation of the Act, and that interpretation is reasonable, HCFA's interpretation is entitled to deference in this case. The Board has repeatedly stated that it will not substitute its judgment for, or overturn, a reasonable interpretation of the agency charged with administering a statute merely because there may be an alternative interpretation which arguably is also permissible. Georgia Dept. of Human Resources, DAB No. 995 (1988); Missouri Dept. of Social Services, DAB No. 468 (1983).

California challenged HCFA's interpretation by arguing that: (1) HCFA misconstrued the law of assignment and its application in TPL cases; (2) HCFA has no right to assert a priority over funds obtained by victims; (3) HCFA misapplied section 1902(a)(25)(B) of the Act; and (4) California's TPL program complies with federal law. Below we explain why we reject California's arguments in this case.

First, California argued that HCFA misconstrued the law of assignment. It pointed out that a Medicaid recipient is required by federal law to assign only his or her rights to payment for medical care. This assignment, California argued, does not prevent a recipient from seeking recovery for other aspects of the injury such as pain and suffering and lost wages. California argued that HCFA had incorrectly assumed that all of the money a recipient recovered from a third party represented the cost of medical care.

However, HCFA did not argue that a recipient cannot seek redress for injuries beyond the cost of medical care nor did it assume that the recipient's recovery must represent only payment for medical care. Rather, HCFA's position is that, where there is a third party or casualty insurer that is responsible for paying a recipient's medical expenses, the

recipient may not recover money for him/herself until the federal government is reimbursed for its expenditures for the recipient's medical care. Moreover, while arguing that HCFA incorrectly assumed that 100% of a recipient's recovery was for medical expenses, California offered no factual basis its assumption that only 50% of a recipient's recovery was medical expenses. Instead, California simply stated that "apportionment done on a 50:50 basis is symbolically fair." California Appeal Brief at 21.

HCFA's position, that it is entitled to be reimbursed first from the recipient's tort recovery, relates to California's second argument. California asserted that HCFA has no right to 'a collection priority over funds obtained by Medicaid recipients in TPL suits for two reasons. First, California argued that the distribution methodology set forth in section 1912(b), on which HCFA relied, establishes a priority in favor of the federal government only when a state initiates and obtains recovery for medical care, not when a recipient brings a legal action. Second, California argued that the distribution methodology set forth in section 1912(b) concerns only payments collected pursuant to assignments for medical care and does not govern distribution of recoveries for payments which are not for medical care.

We do not find these arguments persuasive. The distribution methodology set forth in section 1912(b) must be read in conjunction with section 1902(a)(25)(B), which requires states, not recipients, to seek third party reimbursement. [FN6] Therefore, California has an obligation to seek third party reimbursement to "to the extent of such liability." While California has structured its tort recovery system to encourage lawsuits by recipients and private attorneys rather than the State, it would be inconsistent with the purposes of the provisions to permit this structure to obviate California's obligation under section 1902(a)(25)(B) to seek third party reimbursement or to change the distribution methodology established by section 1912(b). Further, unless these private attorneys are

considered to be acting on behalf of the State so that the "collections" that they effectuate are subject to the distribution requirements of section 1912(b), then California cannot reasonably rely on their efforts as meeting the section 1902(a)(25)(B) requirement.

To allow the distribution of a settlement or an award to turn on whether a recipient or a state initiated the liability action would distort the Medicaid TPL system. Under California's construction, recipients could avoid the third party recovery mandates of the Act simply by instituting the action themselves. California identified no rational basis which would justify such divergent treatment of similarly situated recipients, or the resulting loss to the federal treasury.

California argued further that HCFA had misread section 1912(b) to create a priority for itself over all funds recovered by the recipient. California argued that such a priority ignored the fact that these payments included amounts for things other than medical care. We reject California's construction of section 1912(b) for the following reasons:

- In cases where a third party has caused the need for medical care and is liable for its payment, the Act looks to that third party to reimburse the public. Section 1902(a)(25)(B) requires that "the State . . . will seek reimbursement for such assistance to the extent of such legal liability." HCFA reasonably construed this provision to require states to pursue the full claim against a third party.
- HCFA reasonably read the Act to condition the availability of Medicaid funds on the recipient's agreement to reimburse Medicaid to the extent of a third party's liability. Therefore, Medicaid has superior status to the recipient in relation to the tortfeasor to recover costs Medicaid incurred on behalf of a recipient on the condition that it would be reimbursed if there was a liable third party from whom a recovery was collected.

o HCFA reasonably insisted on its right to characterize recoveries from third parties first as payments for medical care. This characterization prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care (e.g., by suing for pain and suffering or lost wages rather than for medical costs). Without it, TPL recoveries would be subject to a wide range of interpretations about what was appropriately considered payment for medical care.

o Even though California objected to HCFA's assertion of a priority over all the funds recovered by a recipient, its own statutory scheme asserts a priority or "first lien" over a recipient's recovery, no matter how the particular damage components of that recovery might be characterized. Cal. Welf. & Inst. Code § § 14124.71(a); 14124.72(c) and (d); 14124.74(a) and (b). Thus, California recognized that such a priority is essential to effectively collect TPL reimbursement. While California's scheme goes on to limit what California may claim pursuant to its lien and gives the director authority to waive part or all of the lien, the fact is that California asserts a priority over the recipient's entire recovery. [FN7] Therefore, California cannot reasonably maintain that a priority over recipients' damage awards is contrary to the Act.

Third, California argued that section 1902(a)(25)(B) merely provided for a "cost based" determination as to when it was appropriate to seek third party reimbursement and did not constitute "an independent requirement that the state collect the full amount of the cost of providing medical care from the victims' settlement of their claims." California Appeal Brief, at 19. It concluded that section 1902(a)(25)(B) could not be read to "quash or supersede lawful claims of the victim." Id.

We disagree with California's construction of this section. Sections 1902(a)(25)(B) and 1912(b), read together, require states to seek TPL reimbursement and to distribute

any collection first to the Medicaid program and then to the victim. The fact that the victim may have other "lawful claims" for such things as pain and suffering or lost wages does not override Congress' intent, as evidenced by the terms of the Act, that the Medicaid program be fully reimbursed for its expenses before the victim shares in a TPL recovery. The cost-benefit language on which California relied merely creates a common- sense exception to the general federal mandate that states seek TPL recovery. Here, we are not dealing with a few isolated incidents where a state determined that pursuit of a liable third party would not be cost-effective but the recipient nevertheless pursued recovery. Instead, California's scheme is based on recovery by recipients. Failure to apply the distribution priority established in section 1902 (a)(25)(B) in these circumstances would allow a state to defeat Congressional intent.

Fourth, California argued that its "successful third party liability program is in full compliance with the federal law and regulations." California Appeal Brief, at 20. This argument focused on the effectiveness of California's TPL recovery scheme which "balances expectant costs with the potential recovery." Id. Specifically, California argued that, by allowing victims to share in awards, it created an incentive to seek out and pursue liable third parties, thereby maximizing pursuit and shifting initial costs from California to the victim. It argued that the 50% apportionment was fair, created "a reasonable balance between the lawful claims of the victim and California," and ended "the potential legal battle over the limited funds" in which litigants would manipulate awards and settlements to exclude medical damages. Id. at 20, 21. It pointed out that its waiver authority furthered the purposes of the Act by allowing California to condition the use of funds to avoid further public expenses. Finally, it represented that all these factors resulted in a cost effective program.

We do not find these arguments persuasive for the following reasons:

o The alleged effectiveness of California's statutory scheme is not the criteria by which we must evaluate this disallowance. Rather, we must apply the Act, as reasonably interpreted by HCFA. We have explained why, under that criterion,

o California's system does not comply with federal law.

o The role of evaluating the practical considerations that California advanced in support of its system belongs to HCFA, not the Board. As the administering agency, HCFA has the expertise and knowledge to weigh the benefits of California's system against the adverse effects of such a system on the operation of the Medicaid program.

o As for California's assertion that its scheme created a reasonable balance between the victim and the State, that argument ignores the fact that half of the Medi-Cal funds the State is allowing the victim to keep came from the federal treasury. Consequently, HCFA is the entity which is logically charged with the responsibility of deciding what constitutes a "reasonable balance" for this aspect of the Medicaid program. To allow the many jurisdictions which participate in the Medicaid program the discretion to set that balance for third party casualty claims could undermine the TPL system and lead to divergent treatment of similarly situated recipients. Further, as HCFA as informed California, a state is free to allow recipients to retain the state's share of the FFP if they believe that is an equitable result.

o While California maintained that the 50% apportionment is necessary to make the TPL recovery system work, HCFA could reasonably conclude otherwise. For example, even if California had complete priority over the recoveries, private attorneys would continue to have a financial incentive to take these cases because they would continue to be compensated first. Further, recipients are obligated under section 1912(a)(1)(C) to cooperate with California's pursuit of third party payment as a condition of

eligibility, regardless of whether they retain any third party payment.

- Contrary to what California argued, it is not unfair completely or substantially to deny Medicaid recipients access to their settlements. If Medicaid had not paid their medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlements. As Medicaid recipients, they do not have such debts because the public has paid their medical expenses. Therefore, in cases where Medicaid has incurred the "debt" for recipients, it is not unfair for HCFA to require complete reimbursement from these liability funds.
- California is correct that its TPL recovery scheme, by imposing a lien on all of a recipient's recovery no matter how it is characterized, prevents recipients from structuring recoveries to exclude medical damages. However, California has the ability to prevent such problems by amending its statutory scheme to eliminate both the 50% limit on amount it will claim and its discretion to reduce its lien.
- While California represented that its waiver method allows it to condition the use of funds to avoid further public expenses, it is free to use its share of the TPL recoveries to impose such conditions.

In summary, HCFA has the authority and the expertise to interpret the Act and to evaluate the practical considerations involved with seeking third party reimbursement from personal injury settlements and awards. In this case, HCFA has reasonably interpreted the Act to preclude systems which allow recipients to retain TPL payments from which the federal share of Medicaid expenditures has not been deducted.

Conclusion

For the preceding reasons, we uphold this disallowance.

Judith A. Ballard

Cecilia Sparks Ford

M. Terry Johnson

Presiding Board Member

FN1 Section 14124.72(d) provides:

Where the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the director's claim for reimbursement of the benefits provided to the beneficiary shall be limited to the amount of the medical expenditures for the benefit of the beneficiary less 25 percent which represents the director's reasonable share of attorney's fees paid by the beneficiary and that portion of the cost of litigation expenses determined by multiplying the ratio of the full amount of expenditures to the full amount of the judgment, award or settlement.

FN2 Section 14124.78 provides:

Except as otherwise provided in this article, notwithstanding any other provision of law, the entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to . . . [California's] claim for reimbursement of the benefits provided and any lien filed pursuant thereto, but in no event shall [California's] claim exceed one-half of the beneficiary's recovery after deducting for attorney's fees, litigation costs, and medical expenses relating to the injury paid by the beneficiary.

FN3 Section 14124.71(b) provides:

The director may: * * *

(2) Waive any such claim, in whole or in part, for the convenience of the director, or if the director determines that

collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

FN4 For example, in the case of C. M. (State Exhibit 2, line 9), the recipient received $106,983 in Medi-Cal benefits, obtained a liability settlement of $150,000, and incurred $48,506 in attorney's fees and $2,641 in costs. OIGOAS calculated the "net lien" by applying California's 25% percent method: it reduced the Medi-Cal benefits by 25% to account for legal fees ($106,983 x 25% = $26,746) and $1,884 for its pro rata share of costs (($106,983 / $150,000) x $2,641 = $1,884). Thus, OIGOAS determined that the Medi-Cal net lien was $78,353 ($106,983 - $26,746 - $1,884). However, in this case, California applied its 50% method rather than its 25% method and recovered only $49,426 ($150,000 - $48,506 [legal fees] - $2,641 [costs] = $98,853 x 50% = $49,426). OIGOAS therefore determined that there was an overall deficiency of $28,927 ($78,353 [net lien] - 49,426 [California's actual recovery] = $28,927) and a shortfall in the federal reimbursement of $14,463 ($28,927 x 50% FFP = $14,463).

FN5 Further, in 1990, HCFA amended the State Medicaid Manual to provide that "[i]n liability situations, the Medicaid program must be fully reimbursed before the recipient can receive any money from the settlement or award." § 3907 SMM, HCFA Ex. A. Finally, in 1991, HCFA specifically informed California that its method for distributing TPL personal injury settlements and awards was out of compliance with the Act. HCFA Ex. B.

FN6 Under section 1912(a)(1)(c), recipients are required to cooperate with a state's pursuit of TPL reimbursement but they are not required to pursue such reimbursement themselves. The legislative history of this provision states: "The conference agreement follows the Senate amendment with a modification clarifying that individuals are required

to identify, to the extent they are able, potentially liable insurers and other third parties, and to provide information to assist the State in pursuing third parties. Beneficiaries are not required to pursue the collection [of third party reimbursement] themselves. Pursuit is the responsibility of the provider or the State as provided elsewhere in this section." H. R. Conf. Rep. No. 453, at 544-545.

FN7 Further, we note that, until 1976, under California's prior statutory scheme for recovering Medi-Cal expenses from tortfeasors, California was given a 100% priority over the award and did not have to reduce its lien to reflect attorney's fees. The current system was enacted after several state court decisions interfered with California's ability to recover from these awards and settlements. See Reid v. Department of Health Care Services, 55 C.A.3d 418 (1976); Van Nuis v. L.A. Soap Co., 36 C.A.3d 222 (1973). The 50% limitation was included in the final version of the current statutory scheme. It represented a codification of "long-standing settlement guidelines and was added to assure that our lien recovery could not totally deprive a beneficiary of his recovery." Enrolled Bill Report, Bill No. AB3569, dated August 19, 1976 and submitted as an attachment to California letter of November 21, 1994.

Department of Health and Human Services (H.H.S.)
Departmental Appeals Board

Appellate Division

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Docket No. A-95-159
Control No. A-10-93-00017
Decision No. 1561
February 7, 1996

DECISION

The Washington State Department of Social and Health Services (Washington or State) appealed a determination by the Health Care Financing Administration (HCFA) disallowing $75,395 in federal financial participation (FFP) claimed under title XIX (Medicaid) of the Social Security Act (Act). The disallowance represents the federal share of amounts which HCFA determined Washington should have collected from third party liability (TPL) settlements and awards received by Medicaid recipients from June 1, 1992 through August 31, 1993. HCFA determined that these amounts should have been credited against the State's previous claims for its expenditures on behalf of these recipients.

Under Washington law, when the State provides medical assistance to a Medicaid recipient because of an injury for which a third party is liable, Washington is subrogated to the recipient's rights against the recovery from any liable party and has a lien to the extent of the value of the medical assistance provided. This lien is subject to reduction for a proportionate share of attorney's fees, and

may be compromised by the State. This disallowance was based on an audit by the Office of Inspector General (OIG) of ten judgmentally-selected casualty cases closed by the State. The OIG found that $137,032 ($75,395 in FFP) in available settlement monies were distributed by Washington to recipients rather than being retained for full reimbursement to the Medicaid program for its costs of medical assistance under the State's application of its compromise provision (five cases) or its attorney's fees provision (five cases). HCFA determined that, under the Act, HCFA must be fully reimbursed for the federal share before the recipient may receive any money from a TPL settlement or award. HCFA therefore disallowed the federal share of TPL payments that Washington allowed the recipients to retain.

The Board has previously addressed a similar state TPL recovery system in California Dept. of Health Services, DAB No. 1504 (1995) (California). In that decision, the Board concluded that the Act requires states to fully reimburse HCFA for the federal share of medical assistance expenditures resulting from the acts of a liable third party before allowing a recipient to receive money from a TPL settlement or award. HCFA contended that the Board's rationale in that case was controlling here. Washington maintained that its compromise system was materially different from California's, and that its system was consistent with Medicaid TPL requirements. Washington also contended that its attorney's fees provision properly allocated to Medicaid its share of the cost of recovery.

Below we set forth the relevant federal authority and Washington's statutory authority, and we summarize the California decision. We then analyze the parties' arguments in this case and determine that Washington's compromise provision is inconsistent with the Act's TPL recovery provisions, but its attorney's fees provision is consistent. Accordingly, we conclude that the disallowance of the amounts related to the compromise cases should be upheld

and the disallowance of the amounts related to attorney's fees should be reversed.

RELEVANT FEDERAL AUTHORITY

The Act requires a state to take "all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the (Medicaid state] plan...." Section 1902(a)(25)(A). In cases where liability is found to exist after medical assistance is provided, "the State . . . will seek reimbursement for such assistance to the extent of such legal liability." Section 1902(a)(25)(B). A state is not required to seek such reimbursement if "the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery . . . ." Id.

Applicants for Medicaid are required to assign to the state their rights to "payment for medical care from any third party" and to cooperate with the state's pursuit of third party payment. Section 1912(a). The amount collected under such an assignment--

> shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

Section 1912(b).

Legitimate costs of obtaining the settlement or award, such as attorney's fees, may be deducted prior to reimbursement of the Medicaid program. HCFA's State Medicaid Manual (SMM) § 3907, HCFA Exhibit (ex.) A.

RELEVANT WASHINGTON STATUTORY AUTHORITY

Under Washington state law, if Washington provides Medicaid benefits to a recipient because of an injury or

illness for which a third party tortfeasor may be liable, the State is subrogated to the recipient's rights against the tortfeasor or the tortfeasor's insurer, or both, and has a lien to the extent of the value of the Medicaid benefits provided. Wash. Rev. Code § 74.09.180. [FN1] This lien is "upon any claim, right of action, settlement proceeds, money or benefits arising from an insurance program to which the recipient might be entitled . . . ." Wash. Rev. Code § 43.20B.060(3). [FN2] The lien is subject to Wash. Rev. Code § 43.20B.050(1), referred to by the OIG as Washington's compromise provision, which provides that:

No settlement made by and between the recipient and tort feasor and/or insurer shall discharge or otherwise compromise the lien created in RCW 43.208.060 without the express written consent of the secretary [of Social and Health Services] . . . or the secretary's designee. Discretion to compromise such liens rests solely with the secretary or the secretary's designee.

The lien is also subject to Washington's attorney's fees provision:

If recovery is made by the department under this section and the subrogation is fully or partially satisfied through an action brought by or on behalf of the recipient, the amount paid to the department shall bear its proportionate share of attorneys' fees and costs.

Wash Rev. Code § 43.208.060(4). [FN3]

The State provided an affidavit from the chief of the unit responsible for TPL recoveries explaining how these statutory provisions are implemented. See State ex. 12. She stated that, in casualty cases where a third party tortfeasor is alleged to be liable, the State initially asserts a lien in the full amount of medical expenses related to the injuries. The unit later makes a case-by-case analysis of each settlement. Washington may reduce the amount of the lien to less than Medicaid expenditures when the settlement amount is not sufficient to pay all medical expenses and other types of damages. Id. at 2. The unit determines the reduction of the

lien for attorney's fees and costs by taking the total lien amount divided by the total settlement amount to obtain the percentage the State will allow of the attorney's fees and costs as a deduction from the lien amount. Id. at 2-3.

THE CALIFORNIA DECISION

In California, HCFA disallowed the federal share of TPL payments that California allowed recipients to retain even though Medicaid was not fully reimbursed. The Board upheld HCFA's position that the Act requires states to fully reimburse HCFA for the federal share of medical assistance expenditures resulting from the acts of a liable third party before allowing a recipient to receive money from a TPL settlement or award. Specifically, the Board found that three provisions of the Act supported this result:

- Section 1912(a)(1)(A), which requires all recipients to execute an assignment of rights "to payment for medical care from any third party;"
- Section 1902 (a)(25)(B), which requires states to seek TPL reimbursement to the extent of a third party's liability; and
- Section 1912(b), which provides that any amount a state collects under a recipient's assignment to payment for medical care must be used first to reimburse the Medicaid program for medical assistance payments and that the recipient is entitled only to the remainder.

The Board determined that HCFA's position was directly supported by these provisions of the Act. Recipients, as a condition of eligibility, must assign their rights to payment for medical care. States are then charged with the responsibility of seeking third party recovery pursuant to such assignments. States are further required to seek as much reimbursement as possible, i.e., to the extent of the third party's liability. Finally, when a recovery is made, the Act sets forth a distribution scheme which requires the Medicaid program to be reimbursed prior to distributing any funds to

the recipient. While section 1912(a) refers to assignment only of "payment for medical care," the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first.

The Board determined further that HCFA's position is also consistent with the purposes behind Medicaid TPL requirements: to make Medicaid the payor of last resort where there is a liable third party, so as to reduce Medicaid expenditures. In 1985, when Congress amended the Act to strengthen TPL recovery requirements, the accompanying legislative history provided: "Medicaid is intended to be the payor of last resort; that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." Consolidated Omnibus Budget Reconciliation Act of 1985, H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 542 (1985), reprinted in Legislative History of Titles I-XX of the Social Security Act, Vol. XXII, 99th Congress 1985-1986, Part 1. DAB No. 1504, at 7. The Board found that the language clearly indicates that Congress intended for the Medicaid program to be reimbursed from available third party sources to the fullest extent possible.

The Board noted that it had repeatedly held that it will not substitute its judgment for, or overturn, a reasonable interpretation of the agency charged with administering a statute merely because there may be an alternative interpretation which arguably is also permissible. DAB No. 1504, at 8, citing Georgia Dept. of Human Resources, DAB No. 995 (1988); Missouri Dept. of Social Services, DAB No. 468 (1983).

ANALYSIS

Washington argued that HCFA had misapplied the Act, that Washington's TPL process was distinguishable from California's, and that HCFA had approved Washington's TPL process or alternatively, had failed to give it adequate

notice that the process violated the Act. In the first section of analysis we discuss Washington's arguments and explain why we conclude that HCFA is entitled to impose a disallowance as to the compromise cases. In the second section of the analysis we discuss Washington's attorney's fees provision and why the disallowance of costs for payment of attorney's fees should be reversed.

A. The Compromise Provision

1. Whether a state must assert a priority over the recipient's casualty award to the full extent of the state's expenses

Washington argued there was no legal basis in the Act for HCFA's insistence that a recipient "transfer ownership to the state of an entire tort settlement that is insufficient to compensate the recipient for medical and other injuries for which the tortfeasor is liable" or for HCFA's insistence that recipient's assignment of medical damages gives a state a priority over the award to the extent of its costs. Washington Opening Brief (Br.) at 6-7. Washington relied on section 1912(a), which requires a Medicaid recipient to assign his or her rights to payment for medical support and other medical care; on section 1902(a)(25)(A), which requires a state to take reasonable measures to ascertain the legal liability, of third parties to pay for Medicaid care and services; and on section 1912(b), which sets forth the priority for distribution of the amount "collected by the State under an assignment."

The Board dealt with these arguments in California. Below, we restate our reasoning in that case.

First, HCFA has not taken the position that a recipient assigns or loses his/her right to seek compensation for injuries beyond the cost of medical care, nor does HCFA assume that the recipient's recovery represents only payment for medical care. Rather, HCFA's position is that, where there is a third party that is responsible for paying a

recipient's medical expenses, the recipient may not recover money for him/herself until the federal government is reimbursed for its expenditures for the recipient's medical care.

Second, for the following reasons, HCFA may require a state to assert a collection priority over funds obtained by Medicaid recipients in TPL suits even though the distribution methodology set forth in section 1912(b) refers only to payments collected pursuant to assignments for medical care.

- In cases where a third party has caused the need for medical care and is liable for its payment, the Act looks to that third party to reimburse the public. Section 1902(a)(25)(B) requires that "the State . . . will seek reimbursement for such assistance to the extent of such legal liability." HCFA reasonably construed this provision to require states to pursue the full claim against a third party.
- HCFA reasonably read the Act to condition the availability of Medicaid funds on the recipient's agreement to reimburse Medicaid to the extent of a third party's liability. Therefore, Medicaid has superior status to the recipient in relation to the tortfeasor to recover costs Medicaid incurred on behalf of the recipient on the condition that it would be reimbursed if there was a liable third party from whom a recovery was collected.
- HCFA has reasonably insisted on its right to characterize recoveries from third parties first as payments for medical care. This characterization prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care (e.g., by suing for pain and suffering or lost wages rather than for medical costs). Without it, TPL recoveries would be subject to a wide range of interpretations about what was appropriately considered payment for medical care.

Therefore, we reject Washington's position that HCFA has misinterpreted the meaning of sections 1902(a)(25)(A) and 1912(a) and (b) of the Act.

2. Whether Washington's TPL system is distinguishable from California's TPL system

Washington argued that its TPL program was distinguishable from California's because, rather than reserving a statutorily set percentage recovery for Medicaid recipients, Washington reviews the circumstances in each individual settlement. According to Washington, it only approves a compromise which would allow the Medicaid recipient to retain a portion of a settlement when it determines that recovery to the State would be less if it forced the recipient to litigate the question of liability. Washington stated that its goal "in every case is to maximize reimbursement to the Medicaid program" and that "[a] reduction in the State's recovery from a settlement or judgment is only considered when the settlement amount is not sufficient to pay all [medical and non-medical] expenses." Washington Br. at 5.

We do not find Washington's system different from California's in any material way. While Washington asserted that its case-by-case determinations maximize its TPL recoveries, California made similar claims about its system. DAB No. 1504, at 13. Therefore, even though California's system relied on a formula for determining the amount of its recovery, the reason California professed to use the formula (maximizing TPL recoveries) and the result of California's system were the same as in Washington. Under both systems, Medicaid recipients were allowed to retain portions of casualty awards even though the Medicaid program had not been reimbursed to the full extent of its participation in the recipient's costs.

3. Whether HCFA approved Washington's TPL system or failed to give it adequate notice that its TPL system was contrary to the Act

Washington also asserted that HCFA approved Washington's Medicaid state plan with "full knowledge and understanding of the manner and methods employed in casualty recoveries, including compromises, settlement, and attorney fee sharing." Washington Br. at 2. Washington concluded that HCFA should be estopped from imposing this disallowance given its alleged approval of Washington's practices. Id. at 6. We note initially that it is not clear that estoppel will ever lie against the federal government, Office of Personnel Management v. Richmond, 496 U.S. 414, 423-34 (1990), and if available at all, is probably not available absent affirmative misconduct by the federal government. Schweiker v. Hansen, 450 U.S. 785 (1981); see also Wisconsin Dept. of Health and Social Services, DAB No. 1493 (1994). But even if estoppel could lie against HCFA, Washington did not prove the elements of estoppel in this case. A party seeking to assert estoppel must prove that: 1) the party against whom estoppel is sought made false representations; 2) the party claiming estoppel relied on the false representations to the party's detriment; and 3) the reliance was reasonable, in that the party claiming the estoppel neither knew nor should have known that its adversary's conduct was misleading. Heckler v. Community Health Services, 467 U.S. 51, 59 (1984). Further, erroneous oral advice is inadequate, as a matter of law, to estop the government from enforcing federal law. Heckler v. Community Health Services, 467 U.S. at 65; see also Wisconsin at 15. The Supreme Court reasoned in the Community Health Services case:

The necessity for ensuring that governmental agents stay within the lawful scope of their authority, and that those who seek public funds act with scrupulous exactitude, argues strongly for the conclusion that an estoppel cannot be

erected on the basis of the oral advice that underlay respondent's cost reports. That is especially true when a complex program such as Medicare is involved, in which the need for written records is manifest.
467 U.S. at 65.

For the following reasons, Washington has failed to establish that any HCFA official represented to the State in writing that its TPL compromise practice was consistent with the Act.

- Washington argued that by approving its Medicaid state plan, HCFA approved its TPL practices. Washington Br. at 2. However, the provisions of Washington's Medicaid state plan submitted by the State as Exhibit 1 comport with the Act's statutory scheme on their face and do not even allude to Washington's compromise policy. See State ex. 1. Thus, we disagree that HCFA's approval of the state plan provisions somehow equates to HCFA's ratification of the State's practice of compromising TPL recovery on a case- by-case basis.

- Washington also provided an affidavit of a senior program manager of its state TPL system. State ex. 11. That manager claims that HCFA's approval of the Washington State Medicaid plan "was done with full knowledge and understanding of the manner and methods employed in casualty recoveries, including compromises, settlements and attorney fee sharing by the State of Washington. In addition, prior interpretations of policy and law, also provided through HCFA, affirmed the aforementioned as consistent with acceptable practices." State ex. 11 at 2. This affidavit is unpersuasive because it does not identify the manner in which HCFA obtained knowledge of Washington's system, nor specifically assert that HCFA was informed, prior to the OIG audit, that the State was actually allowing Medicaid recipients to retain part of the recovery before Medicaid was reimbursed in situations where this reduced reimbursement of the federal share of medical assistance. The affidavit also

does not identify to which "prior interpretations of policy and law, also provided by HCFA, . . ." the affiant is referring.

- Moreover, HCFA presented an affidavit of a HCFA reviewer that stated that his office informed Washington in 1989 that it should ensure that all possible TPL monies were recovered "in accordance with Federal Regulations which makes [sic] provisions for only the payment of reasonable attorney fees and court costs." HCFA ex. B at 13. Included as an attachment to the affidavits is a 1989 letter from the Associate Regional Administrator, HCFA, directing Washington to submit a corrective action plan.

Washington also contended that it did not have adequate notice that HCFA considered its TPL system to be contrary to the Act. We do not find this contention persuasive. As noted above, HCFA asserted that it informed Washington in 1989 in the course of a program review that it should modify its TPL procedures. Further, in 1990, HCFA amended the State Medicaid Manual (SMM) to provide that "[i]n liability situations, the Medicaid program must be fully reimbursed before the recipient can receive any money from the settlement or award." SMM § 3907. [FN4] This revision put Washington on notice that a compromise of individual settlements permitting a recipient to keep settlement money before the Medicaid, program was fully reimbursed was contrary to HCFA's interpretation of the requirements of the Act.

Thus, Washington's contentions that it did not have notice of HCFA's interpretation of the TPL provisions of the Act and that HCFA should be estopped from taking this disallowance fail. Moreover, in light of our conclusion that Washington was on notice of HCFA's interpretation of the Act's TPL provisions, Washington's argument that HCFA should now be prevented from applying its interpretation of the Act "retroactively" also fails.

4. Whether Washington exercised its compromise authority consistent with federal regulations

Washington argued that it exercised its compromise authority pursuant to 42 C.F.R. § 433.139(f), which grants states a measure of discretion in deciding when to pursue third party reimbursement. Washington explained that in each of the disallowed compromise cases the amount of the settlement was not sufficient to compensate the recipient both for the damages suffered for medical injuries, which were assigned to the State, and for other damages to the recipient like wage loss and pain and suffering. [FN5] Washington Br. at 8. It represented that if it had not compromised its claim, the cases would not have settled and the State would have assumed the risk of an even greater reduction to its claim resulting from an adverse judgment or an unfavorable judicial apportionment of damages. Washington Br. at 9. Therefore, Washington argued, its decision to compromise these claims was within the discretion granted to it by 42 C.F.R. § 433.139(f). That section provides:

(1) An agency must seek reimbursement from a liable third party on all claims for which it determines that the amount it reasonably expects to recover will be greater than the cost of recovery. Recovery efforts may be suspended or terminated only if they are not cost effective.

(2) The State plan must specify the threshold amount or other guideline that the agency uses in determining whether to seek recovery of reimbursement from a liable third party, or describe the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

(3) The State plan must also specify the dollar amount or period of time for which it will accumulate billings with respect to a particular liable third party in making the decision whether to seek recovery of reimbursement.

The State plan provisions submitted by Washington in this case provide for a threshold amount of $20.00. State ex. 1 at sixth unnumbered page ("Attachment 4.22-B").

Washington's statutory compromise provisions are not referenced. The State's TPL recovery unit chief stated that, in the cases involved here --

it was determined, after investigation of the relevant facts and circumstances and discussions with the attorneys involved, that the cost to the Department would be less to compromise the claim, allowing the client to retain some funds, than to force a lawsuit against the responsible party. The costs plus the probability of a defense verdict made it a prudent decision to compromise the Department's lien. State ex. 12, at 2.

Section 433.139(f) does not give Washington the discretion to allow a recipient to retain funds that are due Medicaid. Rather, it requires the State to set forth in its State plan how it determines that the amount it reasonably expects to recover will be greater than the cost of recovery. Here, the State did not set forth the guidelines it uses in determining that pursuit of reimbursement in a particular case is not cost-effective, either in its state plan or in the affidavit of its TPL recovery unit chief. Instead, Washington relied upon its own subjective policy determination that permitting compromise of its liens will maximize TPL recoveries.

We note that California also argued that its system was in full compliance with federal law and regulations on the grounds that it "balance[d] expectant costs with the potential recovery." California at 13. Specifically, California argued that, by allowing victims to share in awards, it created an incentive to seek out and pursue liable third parties, thereby maximizing pursuit and shifting initial costs from California to the victim, and that its program was cost effective.

As in California, we do not find arguments concerning the cost-benefit aspects of Washington's TPL system persuasive for the following reasons:

- The alleged effectiveness of Washington's statutory scheme is not the criterion by which we must evaluate this disallowance. Rather, we must apply the Act, as reasonably interpreted by HCFA. We have explained why, under that

criterion, Washington's system does not comply with federal law.

- The role of evaluating the practical considerations that Washington advanced in support of its system belongs to HCFA, not the Board. As the administering agency, HCFA has the expertise and knowledge to weigh the benefits of Washington's system against the adverse effects of such a system on the operation of the Medicaid program. Moreover, half of the Medicaid funds the State is allowing the victim to keep came from the federal treasury. Consequently, HCFA is the entity which is logically charged with the responsibility of deciding what constitutes a fair balance for this aspect of the Medicaid program. To allow the many jurisdictions which participate in the Medicaid program the discretion to set that balance for third party casualty claims could undermine the TPL system and lead to divergent treatment of similarly situated recipients. Further, as HCFA has said previously, a state is free to allow recipients to retain the state's share of the recovery if the state believes that is an equitable result. California at 14.

- While Washington maintained that its compromise practice was necessary to make its TPL recovery system work, HCFA could reasonably conclude otherwise. For example, even if Washington asserted a complete priority over the recoveries, private attorneys would continue to have a financial incentive to take these cases because they would continue to be compensated first. Further, recipients are obligated under section 1912(a)(1)(C) of the Act to cooperate with Washington's pursuit of third party payment as a condition of eligibility, regardless of whether they retain any third party payment.

- It is not unfair to completely or substantially deny Medicaid recipients access to their settlements. If Medicaid had not paid their medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlements. As Medicaid recipients, they do not have such debts because

the public has paid their medical expenses. Therefore, in cases where Medicaid has incurred the "debt" for recipients, it is not unfair for HCFA to require complete reimbursement from these liability funds.

In summary, HCFA has the authority and the expertise to interpret the Act and to evaluate the practical considerations involved with seeking third party reimbursement from personal injury settlements and awards. In this case, HCFA has reasonably interpreted the Act to preclude systems which allow recipients to retain TPL payments from which the federal share of Medicaid expenditures has not been deducted. For the preceding reasons, we uphold the disallowance of the amounts associated with the five cases in which Washington applied its compromise provision to permit recipients to receive moneys due Medicaid.

B. The Attorney's Fees Provision

Washington contended that its method of calculating attorney's fees properly allocated to Medicaid its appropriate share of the cost of recovery. Washington maintained that the OIG's method imposed all of these costs on the recipient.

Washington offered the following example of how the two systems operated: Assume a $10,000 settlement where attorney's fees (and costs) were $3,000 and Medicaid's outlay for medical expenses was $5,000.

OIG's Method

$10,000	settlement amt.
- 3,000	attorney's fees
7,000	
- 5,000	Medicaid outlay
$ 2,000	recipient's recovery

Washington's Method

$ 5,000	Medicaid outlay	= 50% Medicaid's share of recovery costs
$10,000	settlement amount	
50% ($3,000)	Medicaid's atty's fees % of recovery costs	= $1,5000 Medicaid's share of recovery costs

$10,000	settlement amt.
- 1,500	Medicaid's share of recovery costs
- 5,000	Medicaid's outlay
$ 3,500	recipients recovery

Under the OIG's method, both the attorney's fees and Medicaid's share are deducted before the recipient shares in the recovery. According to Washington, this example shows that the OIG's method results in Medicaid bearing none of the costs of recovery. Under Washington's method, Medicaid is assessed a share of the attorney's fees proportionate with its share of the settlement proceeds -- one-half, in the example displayed above --and the recipient also pays his or her proportionate share of the costs of recovery. Washington contended that its method fairly allocates the costs between the recipient and Medicaid, and comports with SMM § 3907, cited by HCFA, which states, "Legitimate costs of obtaining the settlement or award, such as attorney fees, may be deducted prior to reimbursement to the Medicaid program."

We conclude that Washington's proportional assessment of attorney's fees against the Medicaid program is appropriate. Washington's assessment of attorney's fees is consistent with SMM § 3907, which authorizes deduction of attorney's fees prior to reimbursement of the Medicaid program. [FN6] The OIG method used in this case results in Medicaid bearing none of the legitimate costs of obtaining the settlement and is patently unfair. Moreover, we note that in the California case, California used, without objection from the OIG, a method of deducting attorney's fees from the settlements similar to Washington's.

HCFA's only response to Washington's contention was that the allegedly unfair result was due to the State relying

on private attorneys rather than going after the TPL amount itself, and that Washington cannot abrogate its responsibility in this manner. HCFA's response to Washington's arguments was not persuasive for at least two reasons. First, nothing in the Act or regulations indicates that reliance on private attorneys for pursuit of third party recoveries is impermissible. Second, if the State pursued TPL recovery itself, the same problem would result: the Medicaid program would incur costs for the work of attorneys.

Based on the reasons above, we reverse the portion of the disallowance relating to apportionment of attorney's fees.

CONCLUSION

Based on the above analysis, we uphold HCFA's disallowance of $69,687 FFP for Washington's compromise cases and reverse HCFA's disallowance of $5,708 for Washington's attorney's fees cases. [FN7]

Judith A. Ballard

Cecilia Sparks Ford

M. Terry Johnson

Presiding Board Member

FN1 RCW 74.09.180 reads -- Chapter does not apply where another party liable -- Exception -- Subrogation -- Lien -- Reimbursement. The provisions of this chapter shall not apply to recipients whose personal injuries are occasioned by negligence or wrong of another: PROVIDED, HOWEVER, That the secretary may furnish assistance, under the provisions of this chapter, for the results of injuries to or illness of a recipient, and the department shall thereby be subrogated to the recipient's rights against the recovery had

from any tort feasor or the tort feasor's insurer, or both, and shall have a lien thereupon to the extent of the value of the assistance furnished by the department. To secure reimbursement for assistance provided under this section, the department may pursue its remedies under RCW 43.20B.060.

FN2 RCW 43.20B.060 provides, in pertinent part --

Reimbursement for medical care or residential care -- Lien --Subrogation. (1) To secure reimbursement of any assistance paid under chapter 74.09 RCW or reimbursement for any residential care provided by the department at a hospital for the mentally ill or habilitative care center for the developmentally disabled, as a result of injuries to or illness of a recipient caused by the negligence or wrong of another, the department shall be subrogated to the recipient's rights against the tort feasor or the tort feasor's insurer, or both. (2) The department shall have a lien upon any recovery by or on behalf of the recipient from such tort feasor or the tort feasor's insurer, or both to the extent of the value of the assistance paid or residential care provided by the department, ...

* * *

(3) The lien of the department shall be upon any claim, right of action, settlement proceeds, money, or benefits arising from an insurance program to which the recipient might be entitled (a) against the tort feasor or insurer of the tort feasor, or both, and (b) under any contract of insurance purchased by the recipient or by any other person providing coverage for the illness or injuries for which the assistance or residential care is paid or provided by the department.

FN3 RCW 43.20B.060(4) further provides --

The determination of the proportionate share to be borne by the department shall be based upon: (a) The fees and costs approved by the court in which the action was initiated; or (b) The written agreement between the attorney

and client which establishes fees and costs when fees and costs are not addressed by the court. (c) When fees and costs have been approved by a court, after notice to the department, the department shall have the right to be heard on the matter of attorneys' fees and costs or its proportionate share. (d) When fees and costs have not been addressed by the court, the department shall receive at the time of settlement a copy of the written agreement between the attorney and client which establishes fees and costs and may request and examine documentation of fees and costs associated with the case. The department may bring an action in superior court to void a settlement if it believes the attorneys' calculation of its proportionate share of fees and costs is inconsistent with the written agreement between the attorney and client which establishes fees and costs or if the fees and costs associated with the case are exorbitant in relation to cases of a similar nature.

FN4 Amendments to the SMM are routinely provided to states, and Washington did not deny receiving the amendment in a timely manner.

FN5 For example, in case number 1, the Medicaid payment was $204,055, while the total settlement available was $35,000. In case number 2, the Medicaid payment was $28,320 and the total settlement was $25,000.

FN6 We note that Washington has included provisions in its statute which prevent attorney's fees from being manipulated to impose on the State more than its fair share of a reasonable fee. See text of footnote 3.

FN7 In its disallowance letter, HCFA instructed Washington to "recalculate the distribution of settlements and awards made after August 31, 1993, where your department has applied the state's compromise and attorney fees provisions to casualty cases" and to "make a decreasing adjustment in

the amount determined that should have been retained by your department to fully reimburse Medicaid." Disallowance Letter of June 9, 1995, at 4. In its Notice of Appeal, Washington referred to this "recalculated amount" as being in dispute in this case. Notice of Appeal at 1. In its Reply Brief, Washington argued that, since HCFA's brief had addressed only the $75,395 disallowance, the Board should find that HCFA has acquiesced to the State's position on the issue of recalculation of settlements after August 31, 1993. Reply Brief at 2. To the contrary, it is clear from HCFA's brief that it did not acquiesce to Washington's position that its settlement policy was permissible so that no decreasing adjustment is needed. Consequently, HCFA's direction stands; the effect of this decision, however, is that the State need not recalculate recoveries of attorney's fees. Washington may appeal any future disallowances resulting from its recalculation.

DEPARTMENT Of HEALTH & HUMAN SERVICES
Health Care Financing Administrator

433 (D) - 1-GEN; SEW Region VIII
Federal Office Building
1961 Stout Street
Denver CO 80294

HEALTH CARE FINANCING ADMINISTRATION
REGIONAL IDENTICAL LETTER NO. 94-134

TO: STATE MEDICAID DIRECTORS
SUBJECT: THIRD PARTY LIABILITY RELATIONSHIP TO ISSUE OF LIENS

Federal law at section 1917(a) of the Social Security Act (the Act), and implementing regulations at 42 CFR 433.36 prohibit you from imposing liens against the property of any individual prior to his/her death because of medical assistance paid or to be paid on his/her behalf under the State plan, except in very limited circumstances.

However , section 1902(a)(25)(A) of the Act requires you to ascertain the legal liability of third parties to make payments which Medicaid would otherwise have to make. A third party is defined in the regulations at 42 CFR 433.136 as any individual, entity, or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under the State plan. This includes any monetary judgment or settlement from a tort or casualty liability claim. Where such a legal liability exists, section 1902(a)(25)(B) of the Act requires you to seek reimbursement for medical assistance payments already made.

A Medicaid recipient, at the time of application and as a condition of eligibility for Medicaid, assigns to the State his/her rights to payment from any third party and must

cooperate with you in your pursuit of any third party who might be liable for payment, as required by section 1912(a)(1) of the Act. Thus, under this provision in Federal law and the implementing regulations at 42 CFR 433.145, you have claim to the amount recovered by the recipient, even though you may not have been a party to the litigation.

If, under State law, a lien is not being placed upon the Medicaid recipient's property, but rather is being placed upon the tortfeasor's (the defendant in the personal injury litigation) property or upon funds which are set aside to be used in a settlement of the litigation, but which have not become the recipient's property, then there would be no conflict with section 1917(a) of the Act. This is because section 1917(a) only precludes you from placing a lien on an individual's property.

However, under the circumstances described in this letter, you have an interest in the potential personal injury settlement when a recipient's rights to recover payment for medical care must have been assigned to you under section 1912 of the Act in order for him/her to be eligible for Medicaid. In that event, If you place a lien on these funds, it does not violate the Medicaid statute However, you may not impose a lien on any of the recipient's property which has not been assigned to you.

If you have any questions, please call Sandra White at 303-844-6216, extension 376.

s/_____
Gary Wilks
Associate Regional Administrator
Division of Medicaid

DEPARTMENT Of HEALTH & HUMAN SERVICES
Health Care Financing Administrator

6325 Security Boulevard
Baltimore, MD 21207

TO : ALL STATE MEDICAID DIRECTORS

SUBJECT : Treating Disability Trusts Under Transfer of Assets, Trust, Estate Recovery, and Third Party Liability Rules--
INFORMATION

Transfer and Trust Rules of OBRA '93

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) generally tightened eligibility rules governing the use of trusts by Medicaid applicants and recipients to discourage the transfer or sheltering of income and resources. Section 1917(c) of the Social Security Act (the Act) prescribes a penalty for individuals who transfer assets for less than fair market value. Section 1917(d) requires that States count, for purposes of an individual's Medicaid eligibility, trusts established by an individual (or certain other designated persons) if assets of the individual were used to form all or part of the trust corpus. An individual's "assets", as defined in section 1917(e)(1)(A), include all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or spouse is entitled to but does not receive because of action by the individual or by certain other designated persons or entities.

Recently, several State courts have focused on the right of disabled individuals to receive Medicaid after assets they have received as a third party settlement or award have been placed into a trust. Because of the definition of assets introduced by OBRA '93, the trust and transfer rules could

apply to the proceeds of a disabled individual's settlement with or judgment against a third party, such as a casualty insurance company. The rules could apply if the individual would have otherwise been legally entitled to these proceeds had they not been diverted away from the individual into a trust.

To be covered by the trust rules in section 1917(d), a trust must have been established by an individual, other than by will, with assets of the individual forming all or part of the trust corpus. The trust is considered to have been "established by the individual" if it has been established by the individual; the spouse; a person, including a court or administrative body with legal authority to act in place of or on behalf of the individual or spouse; or by a person, including any court or administrative body acting at the direction or upon the request of the individual or spouse.

If a court establishes a trust on behalf of or at the behalf of an individual, it is covered by the trust rules. If a third party establishes a trust to satisfy a judgment or to pay a settlement, and the trust is required by or approved by a court or administrative body, such a trust also falls within the coverage of section 1917(d). The court or administrative body has acted, in its legal capacity, on behalf of or at the request of the individual, to help establish the trust. Even absent the involvement of the court, if the individual has requested a trust, or accepted the terms of a trust to resolve a claim, the trust established by a third party falls within the coverage of section 1917(d) because the third party's actions are interpreted as those of a person acting at the direction of or upon the request of the individual.

As a general rule, then, a trust which results from a third party award or settlement is regarded as subject to the trust rules. This means that the corpus of the trust, interest on the corpus, and payments from the trust will be considered as

either available resources, income, or as transferred for less than fair market value, depending upon the rules in section 1917(d) relating to how the tract is constructed and how much it can benefit the individual.

There are, however, several exceptions to the general rules which could apply to disability trusts established by third parties. Section 1917(d)(4)(A) says that the trust rules do not apply to a trust containing the assets of a disabled individual under age 65. A second exception which could apply to third party settlements is contained in section 1917(d)(4)(c). This exception applies to "pooled" trusts which contain the assets of a disabled individual if the trust is established and managed by a non-profit association. Separate accounts must be maintained for each trust beneficiary, although these accounts may be pooled for purposes of managing and investing the trust funds.

How Third party Liability (TPL) Rules and Assignment of Rights Affect Trusts

Federal law at section 1902(a)(25)(A) of the Act requires States to take all reasonable measures to ascertain the legal liability of third parties to make payments which Medicaid would otherwise have to make. A third party is defined in the regulations at 42 CFR 433.136 as any individual, entity, or program that is or may be liable to pay all or part of expenditures for medical assistance furnished under the State plan. Where such a legal liability exists, section 1902(a)(25)(B) requires a State to seek reimbursement for medical assistance payments already made.

All individuals, at the time of application and as a condition of eligibility for Medicaid, must assign to the State their rights to payment for medical care from any third party and, subject to several exceptions, must cooperate with the State in its pursuit of any third party who might be liable for such

payment as required by section 1912(a)(1) of the Act and 42 CFR 433.145 of the Medicaid regulations.

Thus, if an individual is already Medicaid eligible at the time he or she receives a third party settlement or judgment, the State has claim to any portion of the proceeds which were intended to pay for medical care for the individual that is covered by Medicaid. If the individual negotiates with the third party to place these amounts in a trust or otherwise fails to help make the amounts available to the State, then that individual has violated the condition of eligibility in section 1912 which requires the individual to cooperate with the State in obtaining payments for medical care from a third party. The individual would lose eligibility, regardless of the trust provisions and exceptions in sections 1917(d)(4)(A) and (C).

If State law permits, a State can place a lien upon a third party's property, as in a situation involving the property of a tortfeasor or defendant in a personal injury suit, or upon funds which are set aside to be used in a settlement, but which have not yet become the property of the Medicaid applicant or recipient.

Section 1917(a) precludes States from placing liens on an individual's property. However, because a potential personal injury settlement is not yet the Plaintiff's property, it can be subject to a TPL lien. Also, proceeds placed in a trust are not the property of the individual, but belong to the trust. As such, a State could place a TPL lien on any proceeds in a trust which could be used to pay for medical care covered in the State's plan, provided there were State laws allowing this.

To avoid the lien issue, but protect its rights, a State could come to an agreement with a plaintiff on the settlement of a tort action in order to get an appropriate share. Alternatively,

the State could intervene in the case and represent its own interests directly. Since the individual has assigned to the State his or her rights to recover payment for medical care under section 1912, the State has an interest which it can represent directly.

When TPL Does Not Affect a Trust

The situation is different if the individual receives a third party settlement or judgment prior to applying for Medicaid. At the time of application, the third party has extinguished its legal liability to the individual by paying off the judgment or providing settlement proceeds. As a result, the individual will no longer have a right to any third party payments to assign to the State. This would be the case, unless the trust itself has the purpose of providing medical care that would otherwise be covered under Medicaid. In the case of such a trust, the State could pursue the trust as a liable third party. However, many trusts established as the result of a judgment or settlement are designed as "supplemental needs" trusts. These kinds of trusts are drafted so that the trustee can only pay for items or services for the individual which are not covered by Medicaid and/or other similar programs.

How the proceeds of a judgment or settlement will affect a disabled individual depends upon their form. If the individual has received the proceeds outright and retained them, they are likely to be counted as income or resources that are available to the individual for eligibility purposes. These proceeds, if large enough, could render the individual ineligible. If, on the other hand, the proceeds have been placed in a trust, the result depends upon whether the general trust rules apply or whether the trust qualifies for an exception.

Trusts Which Meet the Exceptions in Section 1217(d)(4)

A disabled individual might avoid having the trust counted if the trust is designed to meet one of the exceptions in section 1917(d)(4). To qualify for the exceptions, the trust must be established by an appropriate person or entity, as well as meet other requirements. For purposes of section 1917(d)(4)(A), the trust must be established for a disabled individual under age 65 by a parent, grandparent, legal guardian, or a court (but not by the individual). If the trust is established by the court and meets the other (d)(4)(A) requirements, then it would be subject to this exception. If the third party itself establishes the trust at the direction of or upon the request of any of the enumerated parties (all of whom are considered substitutes for the individual), the trust qualifies for this exception, with the third party acting, in effect, at the direction or upon the request of the individual.

The second exception for a disabled individual in section 1917(d)(4)(C) for a "pooled" trust requires that the trust be established and managed by a non-profit association, with an account for the individual established solely for the individual's benefit by the individual, a parent or grandparent, legal guardian, or by a court. Again, if the trust account is established by the court, the exception would apply. The exception would also apply if the third party itself establishes the trust account at the direction of or upon the request of any of the enumerated parties.

Treating Excepted Trusts: Use of Funds and Estate Recovery

If the trust meets one of the exceptions, the State can monitor distributions from the trust to be sure that, in the case of a (d)(4)(A) trust, funds in the trust are used for the benefit of the disabled individual, and in the case of a (d)(4)(C) trust account, solely for the disabled individual's benefit. Once the disabled individual dies, the State must collect whatever

remains in the trust or account (if not retained by the "pooled" trust), up to amount of medical assistance paid by the State.

If the State has not been totally reimbursed from the trust, then the State must follow the estate recovery rules in section 1917(b) of the Act. This provision requires that if an individual has been permanently institutionalized, the State must seek recovery from the individual's estate of any assistance correctly paid or upon sale of a home that has been subject to a lien imposed on account of medical assistance the State has paid.

Section 1917(b) also requires the State to pursue recovery from an individual's estate for the costs of nursing facility services, home and community-based services, and related hospital and prescription drug services, in the case of individuals who received these services when they were age 55 or older. States can also choose to pursue the costs of any other items or services under the State plan for these same individuals.

If you or your staff have any questions concerning the above, please contact your regional office.

s/
Sally R. Richardson
Director
Medicaid Bureau

cc: All Associate Regional Administrators
Division of Medicaid

DEPARTMENT Of HEALTH & HUMAN SERVICES
Health Care Financing Administrator

6325 Security Boulevard
Baltimore, MD 21207

The Honorable Bill Paxon
Member, U. S. House of Representatives
5500 Main Street
Williamsville, New York 14221

Dear Mr. Paxon:

I am responding to your letter to Mr. Richard Tarplin concerning your constituent, Ms. Betty Pattison whose son was injured in an automobile accident. Specifically, Ms. Pattison objects to the fact that the State can place a lien on her son's accident settlement to recover its Medicaid costs. We are unable to provide the relief sought by Ms. Pattison since that is no authority to waive this Federal requirement. I will, however, take this opportunity to provide you with information on the treatment of third party payors.

Section 1902(a)(25)(A) of the Social Security Act (the Act) requires States to the legal liability of third parties to make payments which Medicaid would otherwise have to make. A third party is defined in the regulations at 42 CFR 433.136 as any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under the State plan. This includes any monetary judgment or settlement from a tort or casualty liability claim. Where such a legal liability exists, section 1902(a)(25)(B) of the Act requires a State to seek reimbursement for medial assistance payment already made.

A Medicaid beneficiary, at the time of application and as a condition of eligibility for Medicaid, must assign to the State

his or her rights to payment from any third party and must cooperate with the State in its pursuit of any third party who might be liable for payment, as required by section 1912(a)(1) of the Act. Thus under this provision in federal law and the implementing regulations at 42 CFR 433.145, the States have claim to the amount recovered by the beneficiary, even though the State may not have been a party to the litigation. States may deduct from the settlement, their share of the cost of the attorney fees, as well as litigation and witness costs. Based on section 1912(b) of the Act, a State Medicaid program must be reimbursed before the beneficiary can receive any money from the settlement or award.

Although we are unable to grant relief from the Federal requirement, we hope there will be significant funds remaining for Ms. Pattison's son after Medicaid has recovered its share. If your constituent has any other question, please advise her to contact Mr. Bow Eng in our New York Regional Office at (212) 264-2793.

Sincerely,

s/

Sally K. Richardson
Director
Center for Medicaid and State Operations

cc:
ARA, DMSO
New York

Third Party Liability
In The Medicaid Program

A Guide To Successful State Agency Practices

U.S. Department of
Health and Human Services
Health Care Financing Administration
Medicaid Bureau

A-246

INTRODUCTION

The intent of this "Best Practices Guide" is to provide State Medicaid agencies with information on exemplary practices which could assist States in improving their identification and pursuit of legally liable third party resources. More importantly, the Guide will enable State agencies to identify and assess those practices which have proven to be successful and are transferable to their own State operations. The Guide also makes available State agency reference data to assist States in determining comparability between Medicaid programs.

This is the third edition of the "Best Practices Guide." The original Guide was published in 1984. A second edition was published in 1987. The Guide is being updated again to reflect revisions to practices identified in the previous Guide, to add practices which have been implemented since 1987, and to include practices which are currently being tested in various States. The material in this Guide reflects the best information available as of June 1990.

Background

Federal law and regulations set forth in 42 CFR (Code of Federal Regulations), 433, Subpart D, require States to assure that Medicaid recipients utilize all resources available to them which are legally obligated to pay for all or part of their medical needs before turning to Medicaid. This may involve health insurance, casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more recipients.

The key to saving Medicaid dollars through TPL lies in identifying other insurance available to recipients. The

regulations at 42 CFR 433, Subpart D, also require States to implement various activities to enhance the identification of liable third parties. These activities include (1) collecting health insurance information during the initial eligibility interview process; (2) participating in data exchanges with entities such as State wage information collection agencies and workers' compensation; and (3) conducting diagnosis trauma code edits to detect potential casualty and liability situations.

States use two methods to handle medical claims involving TPL: "cost avoidance" and "pay and chase". States cost avoid claims by requiring the provider of services to bill and collect from liable third parties before sending the claim to Medicaid. Pay and chase occurs when Medicaid pays the recipient's medical bills and then attempts to recover from liable third parties. States are required to cost avoid claims except in specific situations which are set forth in the regulations at Subpart D.

SECTION III - MODEL LEGISLATION # 1

Subrogation Rights of Medicaid Agencies

ARKANSAS
INDIANA
MICHIGAN
** MINNESOTA
** MISSOURI
OHIO
WASHINGTON

1. Abstract - These are basic subrogation laws which give State agencies statutory authority to place their demands ahead of (or as part of) any other claim for payment, against any insurer of a recipient of service, any tort feaser, or insurer of a tort feaser, up to the extent of the value of medical services provided to the recipient.

2. Impact of Model Legislation - These pieces of legislation enable States to enforce their status as "payer of last resort" with respect to services provided under Medicaid, by placing themselves ahead of Medicaid recipients and other claimants, with respect to any health insurance contract and any claim filed against a tort feaser. Subrogation laws in different States are all intended to accomplish the same general purpose, but each law has its own characteristics. Following are laws for a number of States with an example of the required language.

ARKANSAS STATUTE

83-161. Action against third person liable for injury, disease or disability of medical assistance recipient.

A. When medical assistance benefits are provided or will be provided to a medical assistance recipient because of injury,

disease or disability for which another person is liable, the Department of Human Services shall have a right to recover from such person the cost of benefits so provided. The Department may, to enforce such right, institute and prosecute legal proceedings against the third person who may be liable.

B. No action taken on behalf of the Department pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the recipient, his guardian, personal representative, estate or survivors against the third person who may be liable for the injury, or shall operate to deny to the recipient the recovery for that portion of any damages not covered hereunder.

83-171.1. Action against a third person by a medical assistance recipient or a person entitled to bring action.

A. When an action of claim is brought by a medical assistance recipient or his legal representative against a third party who may be liable for injury, disease, disability or death of a medical assistance recipient, any settlement, judgment, or award obtained is subject to the Department's claim for reimbursement of the benefits provided to the recipient under the medical assistance program.

B. (Repealed.)

83-171.2. Action against a third person by the Department and medical assistance recipient.

If an action is prosecuted both by the recipient and the Department against a third person who is liable for injury, disease, or disability of the recipient, in the event of judgment of award in a suit or claim against such third party, the court shall first order paid from any judgment or award the reasonable litigation expenses incurred in

prosecution of such action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the recipient. After payment of such expenses and attorney's fees, the court shall order that the Department receive an amount sufficient to reimburse the Department the full amount of benefits paid on behalf of the recipient under the medical assistance program. The remainder shall be awarded to the medical assistance recipient.

83-171.3 Notice of action or claim - Intervention - Consolidation

A. If either the medical assistance recipient or the Department brings an action or claim against such third person, the recipient or Department shall, within 30 days of filing the action, give to the other written notice of the action or claim by personal service or registered mail. This notice shall contain the names of the third person and the court in which the action is brought. Proof of such notice shall be filed in such action. If an action or claim is brought either by the Department or the recipient, the other may, at any time before a trial on the facts, become a party to the action, or shall consolidate his action or claim with the other if brought independently.

B. If the recipient, his guardian, personal representative, estate or survivors brings an action against the third person who may be liable for injury, disease or disability, notice of institution of legal proceedings and notice of settlement shall be given the secretary of the Department of Human Services. All such notices shall be given by the attorney retained to assert the recipient's claim, or by the recipient, his guardian, personal representative, estate or survivors, if no attorney is retained.

83.171.4. No judgment, award, settlements satisfied without notice to Division - Liability for misuse of funds.

No judgment, award of (or) settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease or disability, in which the Division has interest, shall be satisfied without first giving the Division notice and a reasonable opportunity to establish its interest. If, after being notified in writing of a subrogation claim and possible liability under this section, a recipient, his guardian, attorney, or personal representative disposes, without the written approval of the Division under this section, that person shall be liable to the Division for any amount that, as a result of the disposition of the funds, is not recoverable by the Division.

83-171.5. Liability of third parties to Division.

All parties who were legally liable for any or part of any medical cost of an injury, disease or disability for which the Medicaid program, established by Arkansas Statutes, Section 83-162, has paid, or has assumed liability to pay, shall be liable to the Division of Social Services for the amount of their liability to the extent that the Division of Social Services has paid or agreed to pay.

83.171.6. Assignment to Division of rights of recovery.

The receipt of medical assistance under the Medicaid program shall constitute an automatic assignment to the Division of Social Services of the recipient's right to recovery from personal insurance or other sources or the right of recovery for personal injuries occasioned by the negligence or wrong of another to the extent of the cost of medical care services paid for by the Medicaid program.

83.171.7. Release of information to Division.

All recipients of medical assistance under the Medicaid program shall be deemed to have authorized all third parties including, but not limited to, insurance companies and providers of medical care, to release to the Division of Social Services information needed by the Division to secure or enforce its rights as assignee under Section 4 (83-171.5) of this Act.

83-171.8 Insurance policies - Prohibition against denial or reduction of benefits.

No policy of accident or illness insurance issued or renewed after July 1, 1981, shall contain any provision denial or reducing benefits because services are rendered to an insured or dependent who is eligible for medical assistance under the Arkansas Medicaid program.

83-171.9. Service plan corporation contracts - Prohibition against denial or reduction of benefits.

After July 1, 1981, no service plan corporation shall deliver, issue for delivery, or renew any subscriber's contract which contains any provision denying or reducing benefits because services are rendered to a subscriber or dependent who is eligible for medical assistance under the Arkansas Medicaid program.

83-171.10 Health care providers- Prohibition against denial or reduction of benefits.

After July 1, 1981, no association authorized to do business in this State which provides or pays for any health care benefits shall issue any certificate which contains any provision denying or reducing benefits because services are rendered to a certificate holder or beneficiary who is eligible for medical assistance under the Arkansas Medicaid program.

83-171.11 Exclusion or reduction provisions.

Exclusion or reduction provisions construed as inapplicable to general exclusion or reduction provisions relating to benefits paid by or eligibility under governmental programs, whether State or Federal shall, not be construed to apply to the Medicaid program.

83-171.12 Billing statements.

Billing statements forwarded to recipients of medical assistance by vendors of medical care shall clearly state that reimbursement from the Medicaid program is contemplated.

INDIANA STATUTE

Indiana Code 12-1-7-14.9 (g)

"Insurer" means any insurance company, prepaid health care delivery plan, self-funded employee benefit plan, pension fund, retirement system, or similar entity that:

(1) does business in this State; and
(2) is under an obligation to make payments for medical services as a result of an injury, illness, or disease suffered by an individual.

Indiana Code 12-1-7-24.1

(a) Every applicant for or recipient of medical assistance under this chapter is considered to have authorized all insurers to release to the department all information needed by the department to secure or enforce its rights under this chapter.
(b) Every insurer shall furnish records or information pertaining to the coverage of any individual for that individual's medical costs under any individual or group policy or other obligation, or the medical

benefits paid or claims made under such a policy or obligation, if the department:

(1) requests the information in writing; and

(2) certifies that the individual is:

(A) an applicant for or recipient of medical assistance; or,

(B) is a person who is legally responsible for such an applicant or recipient.

However, the department may request only the records or information necessary to determine whether any insurance benefits have been or should have been claimed and paid with respect to items of medical care and services that were received by a particular individual and for which medical assistance coverage would otherwise be available.

(c) The administrator and the insurance commissioner shall establish guides for information requests under this section.

Indiana Code 12-1-7-24.2

(a) Whenever:

(1) an insurer has not discharged its obligation to make payments to an individual for medical services;

(2) that individual has (received medical assistance) from the department; and

(3) the insurer has (received notice that medical assistance has been furnished to the individual); the insurer shall make its payments directly to the department. These payments shall not exceed the amount of medical assistance paid by the department.

(b) An insurer that is put on notice of a claim by the department under subsection (a) and proceeds to pay the claim to a person or entity other than the department is not discharged from payment of the department's claim.

(c) Payment to the department by an insurer under this section discharges the insurer's obligation with

respect to all further payment on the claim for the amount paid.

(d) The notice requirements of subsection (a) are satisfied if:
   (1) the insurer receives from the department, by certified or registered mail, a statement of the claims or medical services rendered by the department, together with a claim for reimbursement; or,
   (2) the insurer receives a claim from a beneficiary stating that the beneficiary has applied for or has received medical assistance from the department in connection with the same claim.

An insurer that receives a claim under subdivision (2) shall notify the department of its obligation on the claim and shall pay the obligation to the provider of service, or, if the department has provided medical assistance, pay the department.

Indiana Code 12-1-7-24.6

(a) Whenever:
   (1) the department pays medical expenses for or on behalf of a person who has been injured or has suffered a illness or disease as a result of the negligence or act o f another person; and
   (2) the injured or diseased person asserts a claim against the other person for damages resulting from the injury illness or disease; the department has a lien against the other person, to the extent of the amount paid by the department, on any recovery under the claim, whether by judgement, compromise, or settlement.

(b) Whenever:
   (1) the department pays for medical expenses or render medical services on behalf of a person

who has been injured or has suffered an illness or disease; and

(2) that person asserts a claim against any insurer of his injury, illness, or disease; the department has a lien against the insurer, to the extent of the amount paid by the department, on any recovery from the insurer.

(c) A lien under this section is not effective unless the department takes the following actions before the party alleged to be liable has concluded a final settlement with the injured, ill, or diseased person, or his attorney or legal representative, as compensation for that person': injury, illness, or disease.

(1) Filing in the Marion County circuit court a written notice stating:

(A) notice of the eligibility of the injured, ill, or diseased person for medical assistance;

(B) the name and address of the injured, ill, or diseased person; and

(C) the name of the person, firm, or corporation alleged to be liable to the injured, ill, or diseased person.

(2) Sending to the person, firm or corporation alleged to be liable, by registered or certified mail, a copy of the notice required by subdivision (1), with a statement of the date of the filing of that notice.

(d) In addition to the requirements of subsection (c), the department shall send a copy of the notice required by subsection (c)(1) to the following persons or entities, if the appropriate names and address can be determined:

(1) the injured, ill, or diseased person for whom the department has paid medical expenses.

(2) any insurance carrier that may be ultimately liable.

(3) any attorney for the injured or diseased person.

(e) The department may, on behalf of the injured, ill, or diseased person, and to perfect a lien provided by this section, initiate and prosecute any action or proceeding against a person, firm, or corporation who may be liable to the injured, ill, or diseased person. The department may initiate such an action or proceeding only if:

(1) the injured, ill, or diseased person has not initiated legal proceedings against the person, firm, or corporation alleged to be liable; and

(2) the time remaining under the statute of limitations for the action or proceedings is six (6) months or less.

(f) Whenever the department recovers money under a lien established by this section, and that recovery is the result of a claim asserted by an injured, ill, or diseased person, the department shall pay its pro rata share of all costs and reasonably necessary expenses incurred in asserting the claim, including:

(1) disposition costs; (2) witness fees; and (3) other costs and expenses..

(g) The department shall pay attorney fees in the amount of twenty-five percent (25 percent) of the department's recovery under the lien, if the claim was collected without initiating legal proceedings, or thirty-three and one-third percent (33 1/3 percent) of the department's recovery under the lien, if the claim was collected by initiating legal proceedings.

(h) The department may waive its rights to assert a lien under this section. If the department does waive its right to a lien, it is not liable for a pro rata share of costs under subsection (f).

MICHIGAN STATE SUBROGATION STATUTE

400.106 "Medically indigent individual" and "medical institution" defined.

(1) A medically indigent individual is defined as:

(a) An individual receiving aid to dependent children, or an individual eligible for aid to dependent children, or children 18 to 21 eligible for aid to dependent children except for their age, and the adult caretakers living with those children, or a child up to 21 years of age although not receiving aid to dependent children who meets the means test under the Aid to Dependent Children program, or an individual receiving or eligible to receive Supplemental Security Income under title XVI of the Social Security Act, 42 U.S.C. 1381 to 1385, or State supplemental thereunder subject to limitations imposed by the director pursuant to title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k, or

(b) An individual meeting all of the following conditions:

(i) The individual has made application in the manner prescribed by the State department.

(ii) The individual's need for the type of medical assistance available under this Act for which application has been made and the need professionally established and payment for it is not available through the legal obligation of a contractor, public or private, to pay or provide for care without regard to the income or resources of the patient. The department shall be subrogated to any right of recovery which a patient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the department for care and treatment of the patient. The patient or other person acting in the patient's behalf shall execute and deliver an assignment of claim or other authorizations as necessary to secure the right of recovery to the department. A payment may be withheld under this act for medical assistance for an

injury or disability for which the patient is entitled to medical care...or under any other policy of insurance providing medical or hospital benefits, or both for the patient unless the patient's entitlement to that medical care or reimbursement is at issue. If a payment is made, the department, to enforce its subrogation right, may (i) intervene or join in an action or proceeding brought by the injured, diseased, or disabled person, the person's guardian personal representative, estate, dependents, or survivors, against the third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled patient, or (ii) institute and prosecute legal proceeding against a third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled patient, in State of Federal court, either alone or in conjunction with the injured, diseased, or disabled person, the person's guardian, personal representative, State, dependents, or survivors. The Department, in enforcing its subrogation right, shall not satisfy a judgment against third person's property which is exempt from levy and sale. The injured, diseased, or disabled person may proceed in his or her own name, collecting the costs without the necessity of joining the department or the State as a named party. The injured, diseased, or disabled person shall notify the Department of the action or proceeding. An action taken by the disabled person or the Department in connection with the right of recovery afforded by this section shall not operate to deny the injured, diseased, or disabled person any part of the recovery beyond the costs expended on the person's behalf by the Department. The costs of legal action initiated by the State shall be paid by the State. A

payment shall not be made under this act for medical assistance for an injury, disease, or disability for which the patient is entitled to medical care or the cost thereof...; except that payment may be made if an appropriate application for medical care or the cost of the medical care has been made under thereto has not been finally determined, and an arrangement satisfactory to the State Department has been made for reimbursement if the claim under Act No. 317 of the Public Acts of 1969, as amended, if finally sustained.

(iii) The individual has an annual income which is below or, because of medical expenses, falls below the protected basic maintenance level. The protected basic maintenance level for aid to dependent children related families shall be 100 percent of the basic aid to dependent children standard of need. The protected basic maintenance level for related individuals under title XVI of the Social Security Act, 42, U.S.C. 1381 to 1385, shall be established by the State Department in an amount not less than the Supplemental Security Income supplementation standard. These levels shall

(iv) The individual, if an aid to dependent children related to individual and living alone, has liquid or marketable assets of not more than $1,500.00 in value, or, if a 2-person family, the family has liquid or marketable assets of not more-than $2,000.00 in value, the Department shall establish comparable liquid or marketable asset amounts for larger family groups. Excluded in making the determination of the value of liquid or marketable assets are the values of: the homestead, clothing and household effects, $1,000.00 of cash surrender value of life insurance, except if the health o f the insured is such as to make continuance of the insurance desirable, the entire cash surrender value of life insurance is to be excluded from consideration, up to the maximums provided or allowed by Federal regulations and in accordance with the rules of the State Department, the

fair market value of tangible personal property used in earning income, and a space or plot purchased for the purposes of burial for the person. For individuals related to the title XVI program of the Social Security Act, 42 U.S.C. 1381 to 1385, the appropriate resource levels and property exemptions specified therein shall be used.

(v) The individual is not an inmate of a public institution except as a patient in a medical institution.

(vi) The individual meets the eligibility standards for Supplemental Security Income under title XVI of the Social Security Act, 42 U.S.C. 1381 to 1385, or State Supplementation under the Act, subject to limitations imposed by the director pursuant to title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k, or for aid to dependent children, except for income or income and resources, or a child 18 to 21 and his adult caretaker who would be eligible for aid to dependent children except for age, income, or income and resources, or he is a child under 21 from a family whose income is below the basic maintenance level.

(2) As used in the Act, "medical institution" means a State licensed or approved hospital, nursing home, medical care facility, psychiatric hospital, or other facility or identifiable unit thereof certified as meeting established standards for a nursing home or hospital in accordance with the laws and rules of this State.

STATE OF MINNESOTA
256B.37 PRIVATE INSURANCE POLICIES, CAUSES OF ACTION

Subdivision 1. Subrogation. Upon furnishing medical assistance to any person having private accident or health care coverage, or having a cause of action arising out of an occurrence that necessitated the payment of medical assistance, the state agency shall be subrogated to the extent of the cost of medical care furnished to any rights the person may have under the terms of the coverage or under the cause of action.

The right of subrogation created in this section includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

Subd. 2. Civil action for recovery. To recover under this section, the attorney general, or the appropriate county attorney, acting upon direction from the attorney general, may institute or join a civil action to enforce the subrogation rights established under this section.

Subd. 3. Notice. The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the cost of medial care when the state agency has paid or become liable for the cost of care. Notice must be given as follows:

(a) Applicants for medical assistance shall notify the state or local agency of any possible claims when they submit the application. Recipients of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim before filing a claim, commencing an action, or negotiating a settlement.

Notice given to the local agency is not sufficient to meet the requirements of paragraphs (b) and (c).

Subd. 4. Recovery. Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of medical assistance paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency.

STATE OF MISSOURI'S MEDICAID STATUTE RELATING TO SUBROGATION/LIEN/ASSIGNMENT OF BENEFITS

208.215. Subrogation—liens—rights of department, when, procedure, exception—report of injuries required, form—recovery of medical assistance paid, when—1. When any person, corporation, institution, public agency or private agency is liable, either pursuant to contract or otherwise, to a recipient of public assistance on account of personal injury to or disability or disease of the recipient or of a minor on whose behalf public assistance is granted, the department of social services is subrogated to the right of the recipient, minor or estate on whose behalf public assistance is granted to recover from such person from any award or settlement an amount not to exceed the payments made or allowable from medical assistance provided under sections 208.151 to 208.158 and section 208.162 on behalf of the recipient, minor or estate for medical care and treatment on account of the injury, disease, or disability.

2. The department of social services may maintain an appropriate action to recover funds due under this section in the name of the state of Missouri against the person, corporation, institution, public agency or private agency liable to the recipient, minor or estate.

3. Any recipient, minor, guardian, conservator, personal representative, estate, or person entitled under section 537.080, RSMo, to bring an action for wrongful death who pursues legal rights against a person, corporation, institution, public agency or private agency liable to that recipient or minor for injuries, disease or disability as outlined in subsection 1 of this section shall promptly notify the department as to the pursuance of such legal rights.

4. As a condition of eligibility for medical assistance under sections 208.151 to 208.159 and section 208.162, all applicants and recipients, including a person authorized by the probate code, shall cooperate with the department of

social services in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services available under the state's plan for medical assistance at provided in sections 208.152 and 208,162, unless such applicant or recipient has good cause for refusing to cooperate as determined by the department of social services in accordance with federally proscribed standards.

5. Every person, corporation or partnership who acts for or on behalf of a person who is or was eligible for medical assistance under sections 208.151 to 208.159 and section 208.162 for purposes of pursuing the applicant's or recipient's claim which accrued as a result of an incident or occurrence resulting in the payment of medical assistance benefits shall notify the department upon agreeing to assist such person and further shall notify the department of any institution of a proceeding, settlement or the results of the pursuit of the claim.

6. Every recipient, minor, guardian, conservator, personal representative, estate, or person entitled under section 537.080, RSMo, to bring an action for wrongful death, or his attorney or legal representative shall promptly notify the department of any recovery from a third party and shall immediately reimburse the department in full from the proceeds of any settlement, judgment, or other recovery in any action or claim initiated against any such third party.

7. The department director shall have a right to recover the full amount of payments made to a provider under this chapter because of an injury, disease, or disability for which a third party is or may be liable in contract, tort or otherwise under law or equity. The department director is prohibited from reducing the recovery of payments by any fees, costs or other expenditures incurred by any person, corporation or partnership.

8. The department of social services shall have a lien upon any moneys to be paid by any insurance company or similar business enterprise in settlement or satisfaction of a

judgment on any liability claim for injuries which resulted in medical expenses for which the department made payment. This lien shall also be applicable to any moneys which may come into the possession of any attorney who is handling the claim for injuries which resulted in medical expenses for which the department made payment. No such lien shall be effective unless a written notice containing the name and address of the recipient of medical assistance is sent by the department by registered mail, with return receipt requested, to the person, corporation, institution, public agency or private agency alleged to be liable to the recipient prior to the payment of any moneys to such recipient or his attorney or legal representative.

9. From funds recovered pursuant to this section the federal government shall be paid a portion thereof equal to the proportionate part originally provided by the federal government to pay for medical assistance to the recipient or minor involved.

10. The right of subrogation provided by this section is subordinate to the lien provided by section 484.130, RSMo, or section 484.140, RSMo, relating to an attorney's lien and shall be applicable to cases in which workers' disability compensation insurers are the liable third party. The provisions against assignment of this compensation contained in section 287.260, RSMo, shall not be applicable in cases where the state has paid medical assistance benefits.

11. Application for and acceptance of medical assistance under this chapter shall constitute an assignment to the department of social services of any rights to support for the purpose of medical care as determined by a court or administrative order and of any other rights to payment for medical care.

12. All recipients of benefits as defined in this chapter shall cooperate with the state by reporting to the division of family services within thirty days, any occurrences where an injury to their person or to a member of a household who

receives medical assistance is sustained, on such form or forms as provided by the division of family services.

13. If a person fails to comply with the provision of any judicial or administrative decree or temporary order requiring that person to maintain medical insurance on or be responsible for medical expenses for a dependent child, spouse, or ex-spouse, in addition to other remedies available, that person shall be liable to the state for the entire cost of the medical care provided pursuant to eligibility under any public assistance program on behalf of that dependent child, spouse, or ex-spouse during the period for which the required medical care was provided. Where a duty of support exists and no judicial or administrative decree or temporary order for support has been entered, the person owing the duty of support shall be liable to the state for the entire cost of the medical care provided on behalf of the dependent child or spouse to whom the duty of support is owed.

14. The department director or his designee may compromise, settle or waive any such claim in whole or in part in the interest of the medical assistance program.

(L. 1981 H.B. 901 § 1, A.L 1982 H.B. 1086, A.L 1987 H.R. 518)

STATE OF MISSOURI'S WORKERS COMPENSATION STATUTE RELATING TO MEDICAID'S SUBROGATION/LIEN/ASSIGNMENT OF BENEFITS

287.266. Payments made to public assistance recipients to be a debt due state, recovery by state—attorney's fees—assignment of rights—apportionment by judge, when—1. As used in this section, the following terms mean:

(l) "Provider", any individual, corporation, public or private entity that has entered into an agreement with the state to provide any service set out in section 208.152, RSMo, and subsequent amendments;

(2) "Person eligible for public assistance", any individual who is or was eligible for medical assistance under the laws of this state.

2. Payments made to or on behalf of a person eligible for public assistance as the result at any compensable injury, occupational disease or disability as defined by this chapter shall be a debt due the state, and recovery of same shall be a recognized action pursuant to this chapter.

3. The state shall have a lien upon any funds owed by any employer that are or might be due under any insurance agreement or self-insurance authority in effect at the time the medical expense or any portion thereof was paid by the department of social services at its designated division.

4. The state shall have a right of subrogation to any funds owed to or received by the employee or any person, corporation, public agency a private agency acting on his behalf notwithstanding any other provisions of this chapter.

5. The department of social services or its designated division may maintain an appropriate action to recover funds due under this seection pursuant to the workers' compensation law or the second injury fund, which includes the exercise of all appeal rights afforded by the laws of this state.

6. The department shall have a right to recover the full amount of its payments when payments are made to a provider under this chapter if the payments were made on behalf of a person eligible for public assistance for an injury, occupational diiease, or disability which is compensable under this chapter.

7. This, debt due the state shall be subordinate only to the fee rights of the injured employee's attorney pursuant to this chapter, and the state shall not be required to pay any portion of the fees or costs incurred by the employee or the employer.

8. Application for and acceptance of public assistance made to or on behalf of the injured employee shall constitute an assignment of rights to the department of social services for reimbursement of funds expended by the department of social services in the treatment of

9. The attorney shall notify the department of social services upon representation of each client who was eligible for public assistance as provided by sections 208.151 to 208.159, RSMo, and section 208.162, RSMo, prior to, during or subsequent to the date of injury, that the attorney was retained to pursue the client's legal rights related to the compensable injury.

10. The administrative law judge, pursuant to authority granted under section 297.610, shall apportion the debt due the state between the injured worker and the injured worker's employer or their designated representatives when an agreement cannot be reached regarding the respective liability for money expended by the department of social services on behalf of the inured employee, but in no case shall the debt due the state be reduced.

(L. 1987 H.B. 518)

OHIO STATUTE

5101.58 Right of subrogation

The acceptance of aid ... gives a right of subrogation to the Department of Public Welfare and the Department of Welfare of any county against the liability of a third party for the cost of medical services and care arising out of injury, disease, or disability of the recipient. When an action or claim is brought against a third party by a recipient of aid ..., the entire amount of any settlement or compromise of the action or claim, or any court award or judgment is subject to the subrogation right of the Department of Public Welfare of the Department of Welfare of any county. The Departments' subrogation claim shall not exceed the amount of medical expenses paid by the Departments on behalf of the recipient. Any settlement, compromise, judgment, or award that excludes the cost of medical services or care shall not preclude the Departments from enforcing their rights under this section.

Prior to initiating any recovery action, the recipient or his representative shall disclose the identification of any third party against whom the recipient has or may have a right of recovery. Disclosure shall be made to both the Department of Public Welfare and the appropriate County Welfare Department when medical expenses have been paid. No settlement, compromise, judgment, or award or any recovery in any action or claim by a recipient where the Departments have a right of subrogation shall be made final without first giving the appropriate Departments notice and a reasonable opportunity to perfect their rights of subrogation. If the Departments are not given appropriate notice, the recipient is liable to reimburse the Departments for the recovery received to the extent of medical payments made by the

Departments. The Departments shall be permitted to enforce their subrogation rights against the third party even though they accepted prior payments in discharge of their rights under this section if, at the time the Departments received such payments, they were not aware that additional medical expenses had been incurred but had not yet been paid by the Departments. The third party becomes liable to the Department of Public Welfare or County Department of Welfare as soon as the third party is notified in writing of the valid claim for subrogation under this section.

Subrogation does not apply to that portion of any judgment, award settlement of compromise of a claim, to the extent of attorney's fees, costs, or other expenses incurred by a recipient in securing the judgment, award, settlement, or compromise, or to the extent of medical, surgical, and hospital expenses paid by such recipient from his own resources. Attorney fees and costs of other expenses in securing any recovery shall not be assessed against any subrogated claims of the Departments.

To enforce their subrogation rights, the Departments may do any of the following:

(A) Intervene or join in any action or proceeding brought by the recipient or on his behalf against any third party who may be liable for the cost of medical services and care arising out of the recipient's injury, disease, or disability;

(B) Institute and pursue legal proceedings against any third party who may be liable for the cost of medical services and care arising out of the recipient's injury, disease, or disability.

SECTION III - MODEL LEGISLATION # 1

WASHINGTON STATUTE

The revised statute (RCW 43.20B) gives Washington the statutory authority to place demands ahead of claim for payment, against any insurer of a recipient of service, any tort feasor, or insurer of a tort feasor, up to the extent of the value of medical services provided to the recipient. It recognizes prorated court costs and proportionate attorney fees.

This legislation (modified to include attorney notification in 1990) enables Washington to enforce their status as "payor of last resort" with respect to services provided under Medicaid, by inserting themselves ahead of Medicaid recipients and other claimants, into any insurance contract and any claim filed against a tort feasor.

The statutory language in Section 7 is as follows:

(1) To secure reimbursement of any assistance paid under Chapter 74.09 RCW[1] or reimbursement for any residential care provided by the Department at a hospital for the mentally ill or habilitative care center for the developmental disabled, as a result of injuries to or illness of a recipient caused by the negligence or wrong of another, the Department shall be subrogated to the recipient's rights against a tort feasor or the tort feasor's insurer, or both.

(2) The Department shall have a lien upon any recovery by or on behalf of the recipient from such tort feasor or the tort feasor's insurer, or both to the extent of the value of the assistance paid or residential care provided by the Department, provided that such

[1] Chapter 74.09 RCW relates to Medical Assistance payments and RCW 43.20B relates to recovery.

lien shall not be effective against recoveries subject to wrongful death when there are surviving dependents of the deceased. The lien shall become effective upon filing with the county auditor in the county where the assistance was authorized or where any action is brought against the tort feasor or insurer. The lien may also be filed in any other county or served upon the recipient in the same manner as a civil summons if, in the Department's discretion, such alternate filing or service is necessary to secure the Department's interest. The additional lien shall be effective upon filing or service.

3) The lien of the Department shall be upon any claim, right of action, settlement proceeds, money, or benefits arising from an insurance program to which the recipient might be entitled; (a) against the tort feasor or insurer of the tort feasor, or both, and (b) under any contract of insurance purchased by the recipient or by any other person providing coverage for the illness or injuries for which the assistance or residential care is paid or provided by the Department.

(4) If recovery is made by the Department under this section and the subrogation is fully or partially satisfied through an action brought by or on behalf of the recipient, the amount paid to the Department shall bear its proportionate share of attorneys' fees and costs. The determination of the proportionate share to be born by the Department shall be based upon:

(a) The fees and costs approved by the court in which the action was initiated; or

(b) The written agreement between the attorney and client which establishes fees and costs when fees and costs are not addressed by the court.

(c) When fees and costs have been approved by a court, after notice to the Department, the Department shall have the right to be heard on the matter of attorneys' fees and costs, or its proportionate share.

(d) When fees and costs have not been addressed by the court, the Department shall receive at the time of settlement a copy of the written agreement between the attorney and client which established fees and costs and may request and examine documentation of fees and costs associated with the case. The Department may bring an action in superior court to void a settlement if it believes the attorney's calculation of its proportionate share of fees and costs is inconsistent with the written agreement between the attorney and client which establishes fees and costs or if the fees and costs associated with the case are exorbitant in relation to cases of a similar nature.

The new Section 8 is added to Chapter 43.20B RCW to read as follows:

An attorney representing a person who, as a result of injuries or illness sustained through the negligence or wrong of another, has received, is receiving, or has applied to receive assistance under Chapter 74.09 RCW, or residential care provided by the Department at a hospital for the mentally ill or habilitative care center for the developmentally disabled, shall:

(1) Notify the Department at the time of filing any claim against a third party, commending an action at law, negotiating a settlement, or

accepting a settlement offer from the tort feasor or the tort feasor's insurer, or both; and

(2) Give the Department thirty days' notice before any judgment, award, or settlement may be satisfied in any action or any claim by the applicant or recipient to recover damages for such injuries or illness.

PROVISIONS OF WASHINGTON LAW

Recipient or attorney must notify State agency of any third party claim within a reasonable time.

Agency has right to perfect a lien.

Agency will pay a portion of legal fees related to third party information.

Once notified of specific liability, insurers must reimburse the State agency regardless of payments made to others, even if insured is not a recipient but is legally responsible for one.

THIRD PARTY LIABILITY

A State's Opportunity

United States Department of Health and Human Services
Health Care Financing Administration
Bureau of Quality Control

MODEL STATE LEGISLATION - 1983

State Legislation

- **Enactment of State legislation is a key element in a State's pursuit of TPL. Although it is not always possible to evaluate program savings that are directly attributable to legislative enactment, legislation is often the catalyst that gives States the necessary leverage to improve their TPL programs.**

  -- **Subrogation/Assignment of Rights To Medicaid Agencies** - Although subrogation laws vary greatly from State to State, they are the legislative backbone of a TPL program. Subrogation legislation allows a State to stand in place of its Medicaid recipients for the purpose of filing third party claims. Assignment of rights laws reinforce the Federal requirement that, as a condition of eligibility, Medicaid recipients must assign their rights to medical support payments to the State. Both types of legislation have the same end result: To allow the State to stand in for the recipient, thus facilitating State recovery efforts. All States currently have either subrogation or assignment of rights laws.

- **Here are two other examples of important State TPL legislation which have helped States realize greater savings. They are highlighted on the preceding chart.**

  1. **Lien Laws** - An offshoot of subrogation, lien laws give the State statutory authority to perfect liens against judgments made in favor of a Medicaid recipient. Liens enable a State to recover up to the amount the State has paid on behalf of the recipient for medical services. Lien laws can also facilitate

recovery for services normally not covered by health insurance, such as nursing home care.

2. **Payer of Last Resort** - Also related to subrogation laws, these laws state unequivocally that Medicaid is last payer. Some States place this language within the subrogation statute, while others have separate and distinct "last payer" laws. This legislation has been particularly helpful to States dealing with insurance companies which do not always recognize Medicaid's last payer status unless that status is specifically spelled out in State law.

Non-Exhaustive List of States with Medicaid Lien Statutes

Alaska	Alaska Stat. § 47.05.075(a) (West 2001).
California	Cal. Welf. & Inst. Code § 14124.70, et seq. (West 2002).
Colorado	Colo. Rev. Stat. Ann. § 26-4-403(4)(a) (West 2001).
Connecticut	Conn. Gen. Stat. Ann. § 17b-93(a) (West 2002).
Florida	Fla. Stat. Ann. § 409.910(6)(c) (West 2002).
Hawaii	Haw. Rev. Stat. § 346-37(f) (2001).
Iowa	Iowa Code Ann. § 249A.6(1) (West 2002).
Maine	Me. Rev. Stat. Ann. tit. 22, § 14 (West 2001).
Massachusetts	Mass. Gen. Laws Ann. ch. 18, § 5G (West 2002).
Montana	Mont. Code Ann. § 53-2-612 (2001).
New York	N.Y. Soc. Serv. Law § 104b.1 (McKinney 2002).
Oregon	Or. Rev. Stat. § 416.540(2) (2001).
Pennsylvania	62 Pa. Cons. Stat. Ann. § 1409(b)(10) (West 2001).
Utah	Utah Code Ann. § 26-19-5(1)(b) (2001).
Washington	Wash. Rev. Code Ann. § 43.20B.060(2) (2002).

Examples of State Statutes Providing Medicaid Reimbursement from Entire Settlement

Alaska	State lien is "upon any sum that may be due to the recipient of medical assistance from a third-party payor." Alaska Stat. § 47.05.075(a) (West 2001).
California	California's claim is against "the entire amount of any settlement of the injured beneficiary's action or claim." Cal. Welf. & Inst. Code § 14124.78 (West 2002).
Hawaii	State is "subrogated to all rights or claims that a claimant has against the third person for damages not to exceed the full extent of the costs of medical assistance . . ." and "claimant's attorney shall pay the full amount of the lien from the proceeds of any judgment, settlement, or compromise based on the incident or accident." Haw. Rev. Stat. §346-37 (d), (g) (2001).
Iowa	Lien is "upon all monetary claims which the recipient may have against third parties" and "A settlement, award, or judgment structured in any manner not to include medical expenses or an action ... which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the recipient's claim." Iowa Code Ann. § 249A.6.1. (West 2002).

Maine	Lien applies to "proceeds of an award or settlement from a 3rd party if recovery for Medicaid costs was or could have been included in the recipient's claim for damages from the 3rd party." Me. Rev. Stat. Ann. tit. 22 § 14.1. (West 2001).
Montana	Lien "applies to all money paid by a third party . . . regardless of whether the recovery is allocated by the parties or a court to any particular type or element of damages." Mont. Code. Ann. § 53-2-613 (2); § 53-2-612 (3)(i) (2001).
New Jersey	Medicaid recipients must "reimburse the division in full from the proceeds of any settlement, judgment, or other recovery in any action or claim initiated against any such third party. . . ." N.J. Stat. Ann. § 30:4D-7-1.b. (West 2001). *See also In re Kietur*, 332 N.J. Super. 18, 752 A.2d 799 (N.J. Super. Ct. App. Div. 2000)(all proceeds from medical malpractice settlement in minor settlement are subject to state's claim for Medicaid reimbursement, even where settlement funds are designated for pain and suffering and future needs).

Ohio	The "entire amount of any settlement or compromise of the action or claim, or any court award or judgment, is subject to the recovery right of the department. . .[and] any settlement, compromise, judgment, or award that excludes the cost of medical services or care shall not preclude the department from enforcing their (sic) [recovery,] rights under this section." Ohio Rev. Code Ann. § 5101.58 (West 2002).
Pennsylvania	"Except as otherwise provided in this act, notwithstanding any other provision of law, the entire amount of any settlement of the injured beneficiary's action or claim, . . ., is subject to the department's claim for reimbursement . . . ." 62 Pa. Cons. Stat. § 1409.(b)(11) (West 2001).
Utah	"The department's claim to recover medical assistance provided as a result of the injury, disease, or disability is a lien against any proceeds payable to or on behalf of the recipient by that third party." Utah Code Ann. § 26-19-5(1)(b) (2001).
Washington	"Subrogation rights, assignment, or enforcement of the lien granted to the department . . . shall not be reduced, prorated, or applied to only portion judgment, award, or settlement except as provided in R.C.W. 43.20B.050 [compromise by consent of agency] and 43.20B.060 [state share of attorney's fees and costs]." Wash. Rev. Code Ann. § 74.09.185.(3) (2002).

West Virginia	State's subrogation right "includes all portions of the cause of action, by either settlement, compromise, judgment or award, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to the subroption." W. Va. Code § 9-5-11 (a) (2001).

Examples of State Statutes Granting Priority to Medicaid Claim

California	State has "as a first lien against the amount of the settlement ... the reasonable value of additional benefits provided." Cal. Welf. & Inst. Code § 14124.74.(a) (West 2002).
Connecticut	State recovery has "priority over all other unsecured claims and unrecorded encumbrances against such beneficiary for the full amount paid, subject to the provisions of 17b-94 [fees and costs]." Conn. Gen. Stat. Ann. § 17b-93.(a) (West 2002).
Florida	Legislature intends that Medicaid be "repaid in full and prior to any other person, program or entity." Fla. Stat. Ann. § 409.910.(1) (West 2001).
Hawaii	"[D]epartment shall have a first lien in the full amount of the costs of medical assistance or burial payment against the proceeds from all damages awarded in a suit or settlement." Haw. Rev.Stat. § 346-37(f) (2001).
Idaho	State has "priority to any amount received from a third party which can reasonably be construed to compensate the recipient for the occurrence giving rise to the need for medical assistance ... whether or not the recipient is made whole by the amount recovered." Idaho Code § 56-209b(5) (Michie 2001).

Maine	"[D]isbursement of any award, judgment or settlement may not be made to a recipient without ... first paying to the department the amount of the statutory lien from the award, judgment or settlement or obtaining from the department a release of any obligation owed to it for medical benefits provided to the recipient." Me. Rev. Stat. Ann. tit. 22, § 14.2-F. (West 2001).
Utah	State lien "has priority over all other claims to the proceeds, except claims for attorney's fees and costs." Utah Code Ann. § 26-19-5(b) (2001).
West Virginia	*See Grayam v. Dep't of Health and Human Serv.s*, 201 W.Va. 444, 451, 498 S.E.2d 12, 19 (W. Va. 1997)(holding that state law gives state a priority subrogation right to recover full reimbursement from any settlement or judgment against a liable third party).

H.R. Rep. No. 393(11), 95TH Cong.,1ST Sess. 1977, 1977 WL 16075 (Leg.Hist.)
(Cite as: H.R. REP. 95-393(II), 1977 U.S.C.C.A.N. 3039)

****3039** P.L. 95-142, MEDICARE-- MEDICAID ANTIFRAUD AND ABUSE AMENDMENTS
House Report (Ways and Means Committee) No. 95-393(I), June 7, 1977 (To accompany H.R. 3)
House Report (Interstate and Foreign Commerce Committee No. 95-393 (II), July 12, 1977 (To accompany H.R. 3)
Senate Report (Finance Committee) No. 95-453, Sept. 26, 1977 (To accompany S.143)
House Conference Report No. 95-673, Oct. 11, 1977 (To accompany H.R. 3)
Cong. Record Vol. 123 (1977)
DATES OF CONSIDERATION AND PASSAGE
House September 23, October 13, 1977
Senate September 30, October 13, 1977
The House bill was passed in lieu of the Senate bill. House Report No. 95-393(II), and the House Conference Report are set out.

(CONSULT NOTE FOLLOWING TEXT FOR INFORMATION ABOUT OMITTED MATERIAL. EACH COMMITTEE REPORT IS A SEPARATE DOCUMENT ON WESTLAW.)

HOUSE REPORT NO. 95-393(II)
July 12, 1977

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****3040 *1** The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 3) to strengthen the capability of the Government to detect,

prosecute, and punish fraudulent activities under the medicare and medicaid programs, and for other purposes, having considered the same, report favorably thereon with four amendments and recommend that the bill as amended do pass.

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*38 I. LEGISLATIVE BACKGROUND

Legislation to amend the Social Security Act to strengthen the capability of the Government to detect, prosecute and punish fraudulent activities under the medicare and medicaid programs was introduced on January 4, 1977, by Mr. Rogers, Chairman of the Subcommittee and the Environment, and by Mr. Rostenkowski, Chairman of the Subcommittee on Health of the Ways and Means Committee. The bill was subsequently reintroduced as H.R. 3020, H.R. 3021, H.R. 3022, H.R. 3023, H.R. 4087, and H.R. 5702, with an additional 93 members of the House joining as co-sponsors, including 7 members of the Subcommittee on Health and the Environment. Joint hearings were **3041 held by the Health Subcommittees of the Interstate and Foreign Commerce Committee and the Ways and Means Committee on March 3 and 7. The bill was subsequently considered in open executive sessions by the Subcommittee on Health and the Environment, amended, and reported on April 28, 1977. The Subcommittee convened to reconsider the bill after the Ways and Means Committee had completed action, adopted additional amendments, and reported H.R. 3 with amendments on June 13, 1977. H.R. 3 was considered by the Interstate and Foreign Commerce Committee, and ordered reported by voice vote, on June 28, 1977.

The legislation reported by the Committee is a product of close consultation and cooperation throughout the stages of its development with the Committee on Ways and Means. In addition to holding joint hearings, the two Health

Subcommittees held sequential executive sessions to consider the bill in the light of the actions taken by the other Committee members. As a result, both Committees are recommending very similar Committee amendments in reporting the bill to the House.

In order to minimize the differences in the amendments reported by each committee, the Committee on Interstate and Foreign Commerce *39 has included in its reported amendments some provisions which relate solely to part A...

control interest of at least five percent in the institution.

Federal Access to Records (Section 9)

Under present law, State plans under medicaid are required to provide for agreements with every person or institution providing services whereby such persons or entities will keep complete records of services provided under the program and furnish the State agency, upon request, which information regarding any payments claimed under the program. Similar access to records by the Secretary is not required. The committee feels this could hamper Federal efforts to obtain information necessary to examine potential instances of fraudulent and abusive activities. The bill therefore specifically permits the Secretary to have access to records of persons or institutions providing services under medicaid in the same manner presently provided to State medicaid agencies.

Claims Processing and Information Retrieval Systems for Medicaid Programs
(Section 10)

The bill permits States to send explanation of benefits forms to a sample of medicaid recipients and still be entitled to increased Federal matching for operation of approved management information systems. The bill specifies that there would be no explanation of benefit forms in the case of services which are confidential in nature.

Present law authorizes an increase in Federal matching to 75 percent toward the costs of operating an approved medicaid claims processing and information retrieval system if the

system provides explanation of benefits information to all recipients. The committee has been informed that this strict requirement for explanation of *74 benefit forms in every case has limited the growth of approved systems. In addition, questions have been raised about the cost effectiveness of this requirement because of the high volume of claims for services provided under medicaid.

The bill therefore modifies the current requirement by permitting the increased matching if the system provides explanation of benefits information to a sample group of recipients. The committee expects that the samples will be of sufficient size and sufficiently representative of the population served and the services rendered to enable the identification of any questionable or unusual patterns. It is the intention of the committee that all confidential services, and services integrally related to a confidential service, be deleted from the explanation of benefit forms in order to assure privacy for the medicaid patient. States will be expected to institute appropriate safeguards to accomplish this.

**3077 The committee notes that this change in the medicaid statute does not constitute a new entitlement to higher Federal matching, but merely increases the workability of the existing provision.

Medicaid As **Payor** of **Last Resort** (Section 11)

The bill precludes Federal matching payments for expenditures under medicaid for services which a private insurer would have an obligation to pay except for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or receiving medicaid.

Under current law, States or local agencies administering medical assistance plans are required to take all reasonable measures to ensure that third parties legally liable to pay for any medical care rendered to medicaid recipients meet their

legal obligations. However, some private insurance policies contain a provision that limits the insurance companies' liability to the amount not covered by medicaid. In some cases, State insurance commissioners have not taken action to stop this practice. When it occurs, the medicaid program is forced to assume the costs despite the existing subrogation requirement.

The bill would provide an incentive to States to stop this practice by stopping all Federal matching payments for expenditures made under the plan for care or services provided to the extent the private insurer (as defined by the Secretary) would have been obligated to pay except for a provision of its contract which has the effect of limiting or excluding such obligation because the individual is receiving assistance under medicaid.